Fort HealthCare
For Health

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

_____ _____ _____

Name of Patient/Previous Names | Birth Date | Medical Record Number

_____ _____

Street Address, City, State, Zip | Phone Number of Patient

AUTHORIZES DISCLOSURE BY

☐ Fort Memorial Hospital

☐ Fort HealthCare Clinic: _____

FOR THE FOLLOWING DATES:

From: _____

To: _____

DISCLOSURE OF HEALTH INFORMATION TO:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

Phone #_____ Fax#_____

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed:*

☐ Billing Records ☐ Consultation ☐ Discharge Summary ☐ ED Report ☐ History & Physical ☐ Lab Report
☐ Operative Report ☐ Pathology Report ☐ Progress Notes ☐ Radiology Images ☐ Radiology Report ☐ Rehab Notes
☐ Other _____

DISCLOSURES REQUIRING SPECIAL CONSENT: In compliance with Federal/Wisconsin Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply.

☐ Drug/Alcohol Abuse/Treatment ☐ HIV/AIDS* ☐ Mental Health/Behavioral Health Conditions

PURPOSE FOR DISCLOSURE: ***Please provide specific purpose for disclosure or check applicable category.***

☐ Continuing Care ☐ Disability Determination ☐ Insurance/Claim Purposes ☐ Legal
☐ Personal Use ☐ Transfer to New Provider ☐ Vocational Rehab Eval ☐ Workers Compensation
Other: _____

Check One: ☐ Paper Release ☐ Electronic/Digital Release (specify) _____
Release by: ☐ US Mail ☐ Fax _____ ☐ Pick-up Location: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Receive a Copy of the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) of the health information I have authorized to be used or disclosed by this authorization form. **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, I may receive a copy. **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form and that Fort HealthCare may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care is solely for the purpose of creating PHI for disclosure to a third party.** **Right to Withdraw This Authorization** – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Fort HealthCare's Health Information Department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards. ***HIV Test Results**: I understand my HIV test results may be released without authorization to persons/organizations that have access under State laws and a list of those persons/organizations is available upon request. ****WI Statutes 5130 and 252.15** requires patient authorization to disclose health information for payment purposes. **Copy of Facsimile (FAX) Valid as an Original.**

This information has been disclosed to you from records protected by Federal (42 CFR Part 2) and Wisconsin (51.30) confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Expiration Date: This authorization is good until the following dates(s) _____ or 1 year from the date signed.

Signature of Patient/ Legal Rep: _____ DATE: _____ TIME: _____

Relationship to Patient: _____

FHC Employee Witness: _____ DATE: _____ TIME: _____

02/15. *Approved by HIM/UR Committee 12/14/15*