

Information required for a valid Authorization for Disclosures of Health Information. Completed forms can be faxed to (920) 926-8910 or mail to Medical Records, Attention: Release of Information, 420 E. Division Street, Fond du Lac, WI 54935. Your medical records will be sent to those you have designated within eight business days. For more information, call (920) 926-8328.

Section 1.	Regarding Patient/Resident:	<ul style="list-style-type: none"> <li>▪ Name – last, first, middle</li> <li>▪ Street Address/P.O. Box</li> <li>▪ City, State, Zip Code</li> <li>▪ Telephone Number</li> <li>▪ Birthdate</li> </ul>
Section 2.	Health information released to:	<ul style="list-style-type: none"> <li>▪ Name of individual(s)/Organization</li> <li>▪ Street Address/P.O. Box</li> <li>▪ City, State, Zip Code</li> </ul>
Section 3.	I authorize the following facility to disclose the health information identified in Section 4:	<ul style="list-style-type: none"> <li>▪ Check appropriate box(es)</li> </ul>
Section 4.	Specific type of health information to be disclosed:	<ul style="list-style-type: none"> <li>▪ Check appropriate box(es)</li> </ul>
Section 5.	Date(s) of health information to be disclosed:	<ul style="list-style-type: none"> <li>▪ Use this section only if the request is for specific dates to be released (i.e. 10/1/09)</li> <li>▪ If the request is for a verbal communication (indicated in section #6), you must state in this section "Good for 1 year from date signed regarding ..." (specified chronic medical condition(s) that the patient wishes their provider to discuss with person(s) identified in section #2)).</li> </ul> <p>Example: Diabetes – provider to be able to discuss the patient's diabetic condition with their spouse</p>
Section 6.	Disclosure may be in the form of:	<ul style="list-style-type: none"> <li>▪ Check appropriate box</li> </ul>
Section 7.	Purpose of need for disclosure:	<ul style="list-style-type: none"> <li>▪ Check appropriate box</li> </ul>

If the requestor is the patient, complete the following:

Section 8.	I understand that this authorization:	<ul style="list-style-type: none"> <li>▪ Read this section</li> </ul>
Section 9.	I understand:	<ul style="list-style-type: none"> <li>▪ This authorization is valid for only 1 year from the date signed. It is valid only for dates that occur prior to the date signed or specified dates in section 5. This authorization is <b>NOT</b> valid for future dates.</li> </ul> <p>Examples:  Valid: Signed on 1/1/10, information requested for 12/31/09  Invalid: Signed on 1/1/10, information requested for 1/2/10  Invalid: Signed on 1/1/10 with section 5 dated 12/25/09, information requested for 12/30/09</p>
Section 10.	Signature of Patient:	<ul style="list-style-type: none"> <li>▪ Sign and date</li> </ul>

If requestor is **NOT** the patient, complete the following:

Section 11.	<ul style="list-style-type: none"> <li>▪ If signed by person other than patient, complete the following:</li> <li>▪ * Patient is:</li> <li>▪ * Legal authority</li> <li>▪ * For minors:</li> <li>▪ Signature of person legally authorized:</li> </ul>	<ul style="list-style-type: none"> <li>▪ Check appropriate box</li> <li>▪ Check appropriate box</li> <li>▪ Check appropriate boxes</li> <li>▪ Sign and date</li> </ul>
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1. Parents can sign for minors unless the minor is legally emancipated. Anyone over 18 years old or legally emancipated must sign for himself or herself.
2. A spouse can not sign. Exception: if the person has an activated POA over the patient.
3. Stepparents can not sign. Exception: if they adopted the child.
4. If a parent had parental rights or physical placement taken away, they can not sign.
5. If the patient can not sign name, they can place an "X" by name.
6. The Clinic policy is a 24-hour notice for copying of a record. Patient or legal representative have the option of picking up the copied records or having the copies mailed.
7. Patient may sign a release ahead of time to authorize specifically identified individuals to pick up their health information. A valid picture ID is required.
8. If records are for personal, military, legal or insurance use, inform the requestor that there is a charge for these records.
9. No charge for records for continuing medical care.

**STATE OF WISCONSIN**  
**Mandated Release of Information Fee Charge**  
**July 1, 2009**

**Patients:**

REQUESTED INFORMATION	FEE
Paper Copies	\$0.35 plus sales tax per paper page
Microfilm Copies	\$1.25 plus sales tax per microfilm page
Rush Charge	10% of invoice total before sales tax, postage and sales tax



LABEL

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION AGNESIAN HEALTHCARE

MR-465-8 NIS (5/5/09) ORDER FROM PRINTING

**Consultants Laboratory**  
430 E. Division Street  
Fond du Lac, WI 54935

**Fond du Lac Surgery Center**  
421 Camelot Drive  
Fond du Lac, WI 54935

**Fond du Lac Regional Clinic**  
420 E. Division Street  
Fond du Lac, WI 54935

**St. Agnes Hospital**  
430 E. Division Street  
Fond du Lac, WI 54935

**St. Francis Home**  
33 Everett Street  
Fond du Lac, WI 54935

**Waupun Memorial Hospital**  
620 W. Brown Street  
Waupun, WI 53963

**Agnesian HealthCare Enterprises**  
430 E. Division Street  
Fond du Lac, WI 54935

**1. Regarding Patient/Resident**

\_\_\_\_\_  
Name - last, first, middle

\_\_\_\_\_  
Maiden name or other name

\_\_\_\_\_  
Street Address / P.O. Box

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Birthdate

**2. Health information released to:**

Password: \_\_\_\_\_

\_\_\_\_\_  
Name of individual(s) / Organization

\_\_\_\_\_  
Name of individual(s) / Organization

\_\_\_\_\_  
Street Address / P.O. Box OR Additional Name

\_\_\_\_\_  
City, State, Zip Code OR Additional Name

\_\_\_\_\_  
Telephone number OR Additional Name

\_\_\_\_\_  
Fax number OR Additional Name

**3. I authorize the following facility to disclose the health information identified in Section 4:**  St. Agnes Hospital  St. Francis Home

Waupun Memorial Hospital  Consultants Laboratory  Fond du Lac Surgery Center  Agnesian HealthCare Enterprises

Fond du Lac Regional Clinic, site location: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_  
Street

\_\_\_\_\_  
City, State, Zip Code

**4. Specific type of health information to be disclosed:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> All health records (last 2 years)                                    | <input type="checkbox"/> Progress Notes         | <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> Medications       |
| <input type="checkbox"/> History & Physical   | <input type="checkbox"/> Therapy Notes          | <input type="checkbox"/> Outpatient Report   | <input type="checkbox"/> Condition Updates |
| <input type="checkbox"/> Lab Reports  | <input type="checkbox"/> Vision Records         | <input type="checkbox"/> Immunization Record |  |
| <input type="checkbox"/> Medical Imaging:   | <input type="checkbox"/> Other (specify): _____ |  |  |
| <input type="checkbox"/> Films <input type="checkbox"/> Reports <input type="checkbox"/> Echo |   |  |  |

**Health information protected by federal confidentiality rules (42CRF part 2)**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> BH Diagnoses                 | <input type="checkbox"/> BH Mental status exam        | <input type="checkbox"/> BH Attendance                              | <input type="checkbox"/> Psychological testing    |
| <input type="checkbox"/> Drug/alcohol history         | <input type="checkbox"/> BH Physical exam             | <input type="checkbox"/> Psychiatric history                        | <input type="checkbox"/> BH Medication management |
| <input type="checkbox"/> BH Treatment summary or plan | <input type="checkbox"/> BH Initial intake/assessment | <input type="checkbox"/> BH Discharge/summary transfer              | <input type="checkbox"/> Psychotherapy notes      |
| <input type="checkbox"/> AODA                         | <input type="checkbox"/> Hepatitis B                  | <input type="checkbox"/> AIDS (acquired immune deficiency syndrome) |   |
| <input type="checkbox"/> HIV infection                | <input type="checkbox"/> TB (tuberculosis)            | <input type="checkbox"/> STD (sexually transmitted disease(s))      | <input type="checkbox"/> Sickle cell anemia       |
| <input type="checkbox"/> Other: _____                 |   |   |   |

**5. Date(s) of health information to be disclosed:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(CONTINUED ON BACK)



MR-0465

LABEL

**AUTHORIZATION FOR DISCLOSURE OF  
HEALTH INFORMATION  
AGNESIAN HEALTHCARE**

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620 W. Brown Street  
Waupun, WI 53963

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430 E. Division Street  
Fond du Lac, WI 54935

6. **Disclosure may be in the form of:**  Photocopies  Fax  Verbal communication  Inspection  Written correspondence

7. **Purpose or need for disclosure:**  Continuity of care  Personal use  Second opinion  
 Payment of insurance claim  Application for insurance  Legal investigation  Disability determination  
 Other \_\_\_\_\_

8. **I understand that this authorization** may be revoked by me at anytime (except that the facility has already acted in reliance on it) by written notice to the appropriate Medical Records Department. I have the right to inspect and receive a copy of the material to be disclosed and receive a copy of the informed consent. This consent will remain in effect until the above request is processed or unless otherwise specified. When health information is disclosed to anyone except a covered facility it would no longer be protected under HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations. Signing this authorization is voluntary and I may refuse to sign. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits.

**Prohibition of Disclosure:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and Wisconsin Statute 51.30). 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. I understand I may inspect and receive a copy of the disclosed information.

9. **I understand that a photocopy of this consent is as valid as the original. This consent is valid for a period of one (1) year.**

10. **Signature of Patient:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

11. **If signed by person other than the patient, complete the following:**

**Patient is:**  minor  incompetent  disabled  deceased

**Legal authority:**  parent of minor\*  legal guardian  next of kin of deceased  Power of Attorney for HealthCare  
(attach POA document)

**\*For minors:** Are you the parent of the child?  yes  no If so, have you ever been denied custody of this child?  yes  no

**Signature of person legally authorized:** \_\_\_\_\_ **Date signed:** \_\_\_\_\_

<b>OFFICE USE ONLY</b>
Records sent: _____
Copies by: _____
Initials: _____ Date: _____ Time: _____
Released to: _____
Patient's charge for records: _____
This information was:
<input type="checkbox"/> Hand carried by patient
<input type="checkbox"/> Hand carried by _____
<input type="checkbox"/> Mailed first class
<input type="checkbox"/> Express mailed
<input type="checkbox"/> Fax
<input type="checkbox"/> Other: _____



MR-0465