Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
Consultants Laboratory
Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

#### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

(Complete in Full)

1.		I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this		
Name of Patient/Resident		Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my		
Street Address		authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization		
City, State, Zip code		by providing written notice to <u>SSM Health</u> . Revocation of this Authorization will not affect any action taken before receipt of the written revocation.		
Date of Birth	Phone #			
2. I AUTHORIZE THE FOLLOWING FACILITY IDENTIFIED IN SECTION 5:	Y TO DISCLOSE THE HEALTH INFORMATION	3. TO RELEASE PROTECTED HEALTH INFORMATION TO:  (If Release is to Self, State Self)		
☐ St. Agnes Hospital	☐ St. Francis Home			
☐ Waupun Memorial Hospital	☐ Consultants Laboratory	(Name of Physician/Health Care Facility/Other)		
☐ Ripon Medical Center	☐ Agnesian HealthCare Enterprises	(Street Address)		
☐ Villa Loretto	☐ Villa Rosa	(Street Address)		
☐ Christian Home & Rehabilitation	n Center	(City, State, Zip code)		
☐ Fond du Lac Regional Clinic, site	e location:			
		( Fax number)		
Other:		For Pick-Ups, please list who will pick-up records:		
Address:		Name:		
4. PURPOSE OR NEED FOR DISCLOSURE:	(Chack applicable categories)			
□ Continuing Care □ Transferring				
		☐ Legal Investigation ☐ Needed by/Appt. date: / /		
		MM DD YYYY		
Worker's Compensation Research	1 Utner (specify):			



5. HEALTH INFORMATION TO BE RELEASE	D:			
☐ Office Visits ☐ Procedures	☐ Emergency Room Report	☐ Discharge Summary	☐ History & Physical Exam	Operative Reports
☐ Immunization Records ☐ La	ab Reports			
☐ Medical Images (specify):		☐ Billing	Records (specify)	
☐ Specific information related to:				
FOR THE FOLLOWING DATE(S) OR TIME FRA				
☐ Information regarding mental he		R Part 2, AIDS or AIDS-relate	d illness, HIV/AIDS test results, dev	relopmental disabilities, and/or sexually
6. Disclosure may be in the form of:	☐ Photocopies ☐ Fax ☐ Inspec	tion 🗖 CD/DVD 🗖 Ver	bal Disclosure 🔲 email:	
7. EXPIRATION				
This authorization will expire on		If I do not indicate a dat	e, this will expire one (1) year fron	n the date of my signature below.
A photocopy of this authorization is a				
8. SIGNATURE				
	s voluntary. I understand that there	e may be a charge for copie	s. I am confirming my authorization	on that the health care provider may use and
or disclose to the persons and/or org	anizations named in this form the p	protected health informatio	n described in this form.	
Signature:			Date:	
If this Authorization is signed by a re	presentative on behalf of the patie	nt, complete the following:		
Representative's Name (please print)	):		Patient is:  Minor	Incompetent/Incapacitated 🖵 Deceased
Legal Authority: 🖵 Legal Guardian	☐ Parent of Minor ☐ Spouse	of Deceased	are Agent:	
☐ Personal Repres	entative/Domestic Partner of Dece	ased 🗖 Other		
consent of the person to whom it per	rules prohibit you from making an rtains or as otherwise permitted by	ny further disclosure of this i / 42 CFR Part 2. A general au	information unless further disclos athorization for the release of med	confidentiality rules (42 CFR Part 2 and ure is expressly permitted by the written lical or other information is NOT sufficient for atient. I understand I may inspect and receive
10. You are entitled to a copy of this au	thorization after you sign it.			
OFFICE USE ONLY		st:		
Records sent:	Copies by:			
Initials: Ti	ime:			
Released to:				
Patient's charge for records:				
This information was: 🛚 Hand		ed first class		
☐ Hand carried by ☐ Expre	ess mailed			



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#### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

(Complete in Full)

1.		I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this			
Name of Patient/Resident  Street Address		Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my			
		authorization. I may refuse to sign this Authorization, which will not affect my abil to obtain treatment or payment of claims. I have the right to revoke this Authorizati			
City, State, Zip code		by providing written notice to <u>SSM Health</u> . Revocation of this Authorization will no affect any action taken before receipt of the written revocation.			
Date of Birth	Phone #				
2. I AUTHORIZE THE FOLLOWING FACILITY IDENTIFIED IN SECTION 5:	Y TO DISCLOSE THE HEALTH INFORMATION	3. TO RELEASE PROTECTED HEALTH INFORMATION TO: (If Release is to Self, State Self)			
☑ St. Agnes Hospital	☐ St. Francis Home	Post my child's photo on agnesian.com in the web nursery			
☐ Waupun Memorial Hospital	Consultants Laboratory	(Name of Physician/Health Care Facility/Other)			
<ul><li>Ripon Medical Center</li><li>Villa Loretto</li></ul>	<ul><li>Agnesian HealthCare Enterprises</li><li>Villa Rosa</li></ul>	(Street Address)			
☐ Christian Home & Rehabilitation	Center	(City, State, Zip code)			
☐ Fond du Lac Regional Clinic, site	location:				
		(Fax number)			
□ Other:					
Address:		Name:			
4. PURPOSE OR NEED FOR DISCLOSURE: (	(Check applicable categories)				
☐ Continuing Care ☐ Transferring	g Care				
☐ Personal Use ☐ Insurance Elig	ibility/Benefits 🚨 Disability Determination	☐ Legal Investigation ☐ Needed by/Appt. date:///			
☐ Worker's Compensation Research	other (specify): Post photo on webs	ite, post on agnesian.com in the Web Nursery			



5. HEALTH INFORMATION TO BE RELEASED:	
□ Office Visits □ Procedures □ Emergency Room Report □ Discharge Summary □ History	& Physical Exam
☐ Immunization Records ☐ Lab Reports	
☐ Medical Images (specify): ☐ Billing Records (speci	fy)
✓ Specific information related to: Photo of my child	
FOR THE FOLLOWING DATE(S) OR TIME FRAME: From:/	1
MM DD YYYY MM DD  Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/A transmitted infection, unless I limit the disclosure to exclude the following:	IDS test results, developmental disabilities, and/or sexually
<b>6. Disclosure may be in the form of: ☑</b> Photocopies □ Fax □ Inspection □ CD/DVD □ Verbal Disclosure	□ email:
7. EXPIRATION	
This authorization will expire on/	re one (1) year from the date of my signature below.
MM DD YYYY A photocopy of this authorization is as valid as the original.	
8. SIGNATURE I understand that this authorization is voluntary. I understand that there may be a charge for copies. I am confirm or disclose to the persons and/or organizations named in this form the protected health information described in	this form.
Signature: Date:	
If this Authorization is signed by a representative on behalf of the patient, complete the following:	
Representative's Name (please print): Patie	nt is: 🖵 Minor 💢 Incompetent/Incapacitated 💢 Deceased
Legal Authority: 🗅 Legal Guardian 🕒 Parent of Minor 🗅 Spouse of Deceased 🗀 Health Care Agent:	
☐ Personal Representative/Domestic Partner of Deceased ☐ Other	
9. Prohibition of Disclosure for Substance Use Disorder: This information has been disclosed to you from records pro Wisconsin Statute 51.30). The Federal rules prohibit you from making any further disclosure of this information un consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcoh a copy of the disclosed information.	less further disclosure is expressly permitted by the written the release of medical or other information is NOT sufficient for
10. You are entitled to a copy of this authorization after you sign it.	
OFFICE USE ONLY Date of request:	
Records sent:Copies by:	
Initials:   Date:   Time:	
Released to:	
Patient's charge for records:	
This information was:   Hand carried by patient   Mailed first class	
☐ Hand carried by ☐ Express mailed ☐ Fax	
Other:	



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#### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

(Complete in Full)

Name of Patient/Resident	I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further		
Street Address  City, State, Zip code	used or released by persons or organizations receiving it without obtaining m authorization. I may refuse to sign this Authorization, which will not affect my abilit to obtain treatment or payment of claims. I have the right to revoke this Authorization by providing written notice to <u>SSM Health</u> . Revocation of this Authorization will not		
Date of Birth Phone #	affect any action taken before receipt of the written revocation.		
2. I AUTHORIZE THE FOLLOWING FACILITY TO DISCLOSE THE HEALTH INFORMATION IDENTIFIED IN SECTION 5:	3. TO RELEASE PROTECTED HEALTH INFORMATION TO:  (If Release is to Self, State Self)		
□ St. Agnes Hospital □ St. Francis Home  ✓ Waupun Memorial Hospital □ Consultants Laboratory  □ Ripon Medical Center □ Agnesian HealthCare Enterprises  □ Villa Loretto □ Villa Rosa  □ Christian Home & Rehabilitation Center  □ Fond du Lac Regional Clinic, site location:  □ Other: □ Other:	Post my child's photo on agnesian.com in the web nursery  (Name of Physician/Health Care Facility/Other)  Post my child's photo on bulletin board on 4th floor  (Street Address)  (City, State, Zip code)  (Fax number)  For Pick-Ups, please list who will pick-up records:		
Address:	Name:		
4. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)  ☐ Continuing Care ☐ Transferring Care ☐ Personal Use ☐ Insurance Eligibility/Benefits ☐ Disability Determination ☐ ☐ Worker's Compensation Research ☐ Other (specify): Photo of my child, Post my child's photo	MM DD YYYY		



☐ Other:\_

Fax form to: ROI: (920) 926-8910 Medical Imaging (Films): (920) 926-4868

# **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)**

5. HEALTH INFORMATION TO BE RELEASED:				
☐ Office Visits ☐ Procedures	☐ Emergency Room Report	☐ Discharge Summary	☐ History & Physical Exam	Operative Reports
☐ Immunization Records ☐ Lab	Reports			
☐ Medical Images (specify):		☐ Billing	Records (specify)	
✓ Specific information related to:				
FOR THE FOLLOWING DATE(S) OR TIME FRAMI		/ to:		_
	th, substance use disorder, 42CF	R Part 2, AIDS or AIDS-related	l illness, HIV/AIDS test results, dev	relopmental disabilities, and/or sexually
6. Disclosure may be in the form of:	Photocopies 🖵 Fax 🖵 Inspe	ction 🗖 CD/DVD 🗖 Verl	oal Disclosure 🔲 email:	
7. <b>EXPIRATION</b> This authorization will expire on A photocopy of this authorization is as		If I do not indicate a date	e, this will expire one (1) year fron	n the date of my signature below.
8. SIGNATURE I understand that this authorization is or disclose to the persons and/or organ				on that the health care provider may use and,
Signature:			_ Date:	
If this Authorization is signed by a repr	esentative on behalf of the patie	ent, complete the following:		
Representative's Name (please print):			Patient is: 🗹 Minor 🗆	Incompetent/Incapacitated 🖵 Deceased
Legal Authority: 🖵 Legal Guardian	<b>≰</b> Parent of Minor □ Spouse	of Deceased 🔲 Health Ca	re Agent:	
☐ Personal Represer	ntative/Domestic Partner of Dece	eased 🖵 Other		
consent of the person to whom it perto	ules prohibit you from making a nins or as otherwise permitted b	ny further disclosure of this i y 42 CFR Part 2. A general au	nformation unless further disclos chorization for the release of med	confidentiality rules (42 CFR Part 2 and ure is expressly permitted by the written lical or other information is NOT sufficient for atient. I understand I may inspect and receive
10. You are entitled to a copy of this auth	orization after you sign it.			
OFFICE USE ONLY	Date of reque	est:		
Records sent:	Copies by:			
Initials: Tim	Je.			
Released to:				
Patient's charge for records:				
This information was:   Hand of	arried by patient 🔲 Mai	led first class		
☐ Hand carried by ☐ Expres	s mailed 🔲 Fax			- 現の思



Agnesian HealthCare Enterprises
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#### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

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1.		I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this		
Name of Patient/Resident		Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my		
Street Address		authorization. I may refuse to sign this Authorization, which will not affect my abilit to obtain treatment or payment of claims. I have the right to revoke this Authorizatio		
City, State, Zip code		by providing written notice to <u>SSM Health</u> . Revocation of this Authorization will not affect any action taken before receipt of the written revocation.		
Date of Birth	Phone #			
2. I AUTHORIZE THE FOLLOWING FACILIT IDENTIFIED IN SECTION 5:	Y TO DISCLOSE THE HEALTH INFORMATION	3. TO RELEASE PROTECTED HEALTH INFORMATION TO:  (If Release is to Self, State Self)		
☑ St. Agnes Hospital	☐ St. Francis Home			
☐ Waupun Memorial Hospital	☐ Consultants Laboratory	(Name of Physician/Health Care Facility/Other)		
Ripon Medical Center	☐ Agnesian HealthCare Enterprises	(Street Address)		
Villa Loretto	☐ Villa Rosa	(street Address)		
☐ Christian Home & Rehabilitation	n Center	(City, State, Zip code)		
☐ Fond du Lac Regional Clinic, site	e location:			
		( Fax number)		
Other:		For Pick-Ups, please list who will pick-up records:		
Address:		Name:		
4. PURPOSE OR NEED FOR DISCLOSURE:				
☐ Continuing Care ☐ Transferrin				
		☐ Legal Investigation ☐ Needed by/Appt. date://		
☐ Worker's Compensation Research	h 🗹 Other (specify): communication with	those identified		



☐ Other:\_

Fax form to: ROI: (920) 926-8910 Medical Imaging (Films): (920) 926-4868

# **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)**

5. HEALTH INFORMATION TO BE RELEASED				
☐ Office Visits ☐ Procedures	☐ Emergency Room Report	☐ Discharge Summary	☐ History & Physical Exam	Operative Reports
☐ Immunization Records ☐ Lab		,	. ,	
☐ Medical Images (specify):		☐ Billing	Records (specify)	
✓ Specific information related to:				
FOR THE FOLLOWING DATE(S) OR TIME FRAM				_
	lth, substance use disorder, 42CF	R Part 2, AIDS or AIDS-related	l illness, HIV/AIDS test results, dev	relopmental disabilities, and/or sexually
6. Disclosure may be in the form of: $\Box$	Photocopies	ction 🗖 CD/DVD 🗹 Verl	oal Disclosure 🔲 email:	
7. EXPIRATION This authorization will expire on A photocopy of this authorization is as		If I do not indicate a date	e, this will expire one (1) year fron	n the date of my signature below.
8. SIGNATURE I understand that this authorization is or disclose to the persons and/or organ				on that the health care provider may use and,
Signature:			_ Date:	
If this Authorization is signed by a repo	resentative on behalf of the patie	ent, complete the following:		
Representative's Name (please print):			Patient is: 🗖 Minor 🗆	Incompetent/Incapacitated 🖵 Deceased
Legal Authority: 🖵 Legal Guardian	☐ Parent of Minor ☐ Spouse	of Deceased 🔲 Health Ca	re Agent:	
☐ Personal Represe	ntative/Domestic Partner of Dece	ased 🗖 Other		
consent of the person to whom it pert	rules prohibit you from making an ains or as otherwise permitted b	ny further disclosure of this i y 42 CFR Part 2. A general au	nformation unless further disclos thorization for the release of med	confidentiality rules (42 CFR Part 2 and ure is expressly permitted by the written lical or other information is NOT sufficient for atient. I understand I may inspect and receive
10. You are entitled to a copy of this auth	orization after you sign it.			
OFFICE USE ONLY	Date of reque	est:		
Records sent:	Copies by:			
Initials: Tin	ne:			
Released to:				
Patient's charge for records:				
This information was:  Hand o	* *	led first class		
☐ Hand carried by ☐ Expres	ss mailed 🔲 Fax		1	. • KOA29.



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#### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

(Complete in Full)

Name of Patient/Resident	I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my		
Street Address  City, State, Zip code  Date of Birth Phone #	authorization. I may refuse to sign this Authorization, which will not affect my abil to obtain treatment or payment of claims. I have the right to revoke this Authorizatio by providing written notice to <u>SSM Health</u> . Revocation of this Authorization will raffect any action taken before receipt of the written revocation.		
2. I AUTHORIZE THE FOLLOWING FACILITY TO DISCLOSE THE HEALTH INFORMATION IDENTIFIED IN SECTION 5:	3. TO RELEASE PROTECTED HEALTH INFORMATION TO:  (If Release is to Self, State Self)		
✓ St. Agnes Hospital □ St. Francis Home □ Waupun Memorial Hospital □ Consultants Laboratory □ Plines Medical Contex	(Name of Physician/Health Care Facility/Other)		
<ul> <li>□ Ripon Medical Center</li> <li>□ Villa Loretto</li> <li>□ Villa Rosa</li> <li>□ Christian Home &amp; Rehabilitation Center</li> </ul>	(Street Address) (City, State, Zip code)		
☐ Fond du Lac Regional Clinic, site location:	(Fax number)		
Other:Address:	For Pick-Ups, please list who will pick-up records:  Name:		
4. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)  ☑ Continuing Care ☐ Transferring Care ☐ Personal Use ☐ Insurance Eligibility/Benefits ☐ Disability Determination ☐ Worker's Compensation Research ☐ Other (specify):	□ Legal Investigation □ Needed by/Appt. date:/		



☐ Other:\_

Fax form to: ROI: (920) 926-8910 Medical Imaging (Films): (920) 926-4868

## **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)**

5. HEALTH INFORMATION TO BE RELEASED:	:			
☐ Office Visits ☐ Procedures	☐ Emergency Room Report	☐ Discharge Summary	☐ History & Physical Exam	☐ Operative Reports
☐ Immunization Records ☐ Lab	Reports			
☐ Medical Images (specify):		☐ Billing	Records (specify)	
✓ Specific information related to:				
FOR THE FOLLOWING DATE(S) OR TIME FRAM		/ to:		
	lth, substance use disorder, 42CFF	R Part 2, AIDS or AIDS-related	l illness, HIV/AIDS test results, dev	relopmental disabilities, and/or sexually
6. Disclosure may be in the form of: $\Box$	Photocopies 🖵 Fax 🖵 Inspec	ction 🗖 CD/DVD 🗹 Verl	oal Disclosure 🔲 email:	
7. EXPIRATION This authorization will expire on A photocopy of this authorization is as		If I do not indicate a date	e, this will expire one (1) year fron	n the date of my signature below.
8. SIGNATURE I understand that this authorization is or disclose to the persons and/or organ				on that the health care provider may use and
Signature:			_ Date:	
If this Authorization is signed by a repr	esentative on behalf of the patie	ent, complete the following:		
Representative's Name (please print):			Patient is: 🗖 Minor 🗆	Incompetent/Incapacitated 🖵 Deceased
Legal Authority: 🖵 Legal Guardian	☐ Parent of Minor ☐ Spouse	of Deceased	re Agent:	
Personal Represer	ntative/Domestic Partner of Dece	ased 🗖 Other		
consent of the person to whom it perto	ules prohibit you from making ar ains or as otherwise permitted by	ny further disclosure of this in y 42 CFR Part 2. A general au	nformation unless further disclos chorization for the release of med	confidentiality rules (42 CFR Part 2 and ure is expressly permitted by the written lical or other information is NOT sufficient for atient. I understand I may inspect and receive
10. You are entitled to a copy of this auth	orization after you sign it.			
OFFICE USE ONLY	Date of reque	est:		
Records sent:	Copies by:			
Initials: Tin	no.			
Released to:				
Patient's charge for records:				
This information was:   Hand of	carried by patient 🔲 Mail	ed first class		
☐ Hand carried by ☐ Expres	ss mailed			- 現の思



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### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

(Complete in Full)

1.		I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this		
Name of Patient/Resident		Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my		
Street Address		authorization. I may refuse to sign this Authorization, which will not affect my abilit to obtain treatment or payment of claims. I have the right to revoke this Authorization		
City, State, Zip code		by providing written notice to <u>SSM Health</u> . Revocation of this Authorization will not affect any action taken before receipt of the written revocation.		
Date of Birth	Phone #			
2. I AUTHORIZE THE FOLLOWING FACI IDENTIFIED IN SECTION 5:	LITY TO DISCLOSE THE HEALTH INFORMATION	3. TO RELEASE PROTECTED HEALTH INFORMATION TO:  (If Release is to Self, State Self)		
☐ St. Agnes Hospital	☐ St. Francis Home			
☑ Waupun Memorial Hospital	Consultants Laboratory	(Name of Physician/Health Care Facility/Other)		
☐ Ripon Medical Center	☐ Agnesian HealthCare Enterprises	(Street Address)		
☐ Villa Loretto	☐ Villa Rosa	(Street Address)		
☐ Christian Home & Rehabilitat	tion Center	(City, State, Zip code)		
☐ Fond du Lac Regional Clinic,	site location:			
		( Fax number)		
□ Other:		For Pick-Ups, please list who will pick-up records:		
Address:		Name:		
4. PURPOSE OR NEED FOR DISCLOSUF	, , ,			
☐ Continuing Care ☐ Transfer				
		□ Legal Investigation □ Needed by/Appt. date://		
☐ Worker's Compensation Resea	arch other (specify): communication with	h those identified		



5. HEALTH INFORMATION TO BE RELEASED	ı:			
☐ Office Visits ☐ Procedures	☐ Emergency Room Report	☐ Discharge Summary	☐ History & Physical Exam	Operative Reports
☐ Immunization Records ☐ Lal	b Reports			
☐ Medical Images (specify):		Billing	Records (specify)	
✓ Specific information related to:	health information related to	this encounter		
FOR THE FOLLOWING DATE(S) OR TIME FRAM				
	alth, substance use disorder, 42CF	R Part 2, AIDS or AIDS-relate	d illness, HIV/AIDS test results, dev	velopmental disabilities, and/or sexually
6. Disclosure may be in the form of: $\Box$	Photocopies	ction 🖵 CD/DVD 🗹 Ver	bal Disclosure 🔲 email:	
7. EXPIRATION This authorization will every an	1	If I do not indicate a dat	a thic will avaire one (1) year from	n the date of musicipature heleur
This authorization will expire on		II I do not maicate a dat	e, this will expire one (1) year nor	if the date of my signature below.
A photocopy of this authorization is as	s valid as the original.			
8. SIGNATURE  I understand that this authorization is or disclose to the persons and/or orga				on that the health care provider may use and,
Signature:			Date:	
If this Authorization is signed by a rep				
Representative's Name (please print):			Patient is: 🗖 Minor 🗆	☐ Incompetent/Incapacitated ☐ Deceased
☐ Personal Represe	ntative/Domestic Partner of Dece	eased 🗖 Other		
consent of the person to whom it per	rules prohibit you from making a tains or as otherwise permitted b	ny further disclosure of this by 42 CFR Part 2. A general au	information unless further disclos athorization for the release of med	confidentiality rules (42 CFR Part 2 and ure is expressly permitted by the written dical or other information is NOT sufficient for atient. I understand I may inspect and receive
10. You are entitled to a copy of this auth	norization after you sign it.			
OFFICE USE ONLY	Date of reque	est:		
Records sent:	Copies by:			
Initials: Tir	me.			
Released to:				
Patient's charge for records:				
This information was:	carried by patient 🚨 Mai	led first class		<b></b>
☐ Hand carried by ☐ Expre	ss mailed 🔲 Fax	<u>'</u>		<b>国教</b> 国



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Christian Home & Rehabilitation Center
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Waupun Memorial Hospital

### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

(Complete in Full)

				(*****	J				
Name o	Name of Patient/Resident  Street Address					I authorize the use and/or release of my protected health information as describe below. I understand that the information used or released as a result of th Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining many that is a superior or organization of the superior of the superior or organization or organizations.			
Street /						authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization			
City, State, Zip code					- 11	by providing written notice to <u>SSM Health</u> . Revocation of this Authorization will not affect any action taken before receipt of the written revocation.			
Date of Birth Phone #				Phone #	-				
	JTHORIZE TI NTIFIED IN 1		O DISC	CLOSE THE HEALTH INFORMATION	3.	TO RELEASE PROTECTED HEALTH INFORMATION TO: (If Release is to Self, State Self)			
	St. Agnes	Hospital		St. Francis Home					
	Waupun I	Memorial Hospital		Consultants Laboratory		(Name of Physician/Health Care Facility/Other)			
	Ripon Me Villa Lore	dical Center				(Street Address)			
		no Home & Rehabilitation C	_	VIIIa ROSa		(City, State, Zip code)			
		ac Regional Clinic, site lo				(city, state, zip toue)			
	Toria da E	ac regional enine, sice to	cation	•		( Fax number)			
<b>4</b>	Other:	Doll and Associates		Phone: (920) 907-8201	_	For Pick-Ups, please list who will pick-up records:			
	Address:	40 Camelot Drive		Fax: (920) 907-8209		Name:			
		Fond du Lac, WI 549	935		_				
		EED FOR DISCLOSURE: (C		pplicable categories)					
	_	Care   Transferring C							
	Personal U	se 🔲 Insurance Eligib	ility/B	enefits  Disability Determination	☐ Lega	I Investigation    Needed by/Appt. date:    MM    DD    YYYY			
	Worker's C	ompensation Research	<b>0</b>	ther (specify):					



5. HEALTH INFORMATION TO BE RELEASED	ı:			
☐ Office Visits ☐ Procedures	☐ Emergency Room Report	☐ Discharge Summary	☐ History & Physical Exam	Operative Reports
☐ Immunization Records ☐ Lal	b Reports			
☐ Medical Images (specify):		☐ Billing	Records (specify)	
Specific information related to:	BH diagnoses, treatment plan/sum	ımary, BH assessments, psyc	chotherapy notes, discharge sumr	nary, transfer summary, psychological
· to	esting, attendance history, mental		1 1	
FOR THE FOLLOWING DATE(S) OR TIME FRAM				
				relopmental disabilities, and/or sexually
6. Disclosure may be in the form of:	Photocopies 🗹 Fax 🖵 Inspec	tion 🗅 CD/DVD 🗹 Ver	bal Disclosure 🔲 email:	
7. EXPIRATION				
This authorization will expire on		If I do not indicate a dat	e, this will expire one (1) year fron	n the date of my signature below.
A photocopy of this authorization is as				
8. SIGNATURE				
				on that the health care provider may use and
or disclose to the persons and/or orga				
Signature:			Date:	
If this Authorization is signed by a rep	resentative on behalf of the patie	nt, complete the following:		
Representative's Name (please print):			Patient is: 🗖 Minor 🗆	Incompetent/Incapacitated 🖵 Deceased
Legal Authority: 🗖 Legal Guardian	☐ Parent of Minor ☐ Spouse	of Deceased 🔲 Health Ca	are Agent:	
☐ Personal Represe	ntative/Domestic Partner of Decea	ased 🗖 Other		
consent of the person to whom it pert	rules prohibit you from making an tains or as otherwise permitted by	ny further disclosure of this i v 42 CFR Part 2. A general au	nformation unless further disclos thorization for the release of med	confidentiality rules (42 CFR Part 2 and ure is expressly permitted by the written lical or other information is NOT sufficient for atient. I understand I may inspect and receive
10. You are entitled to a copy of this auth	norization after you sign it.			
OFFICE USE ONLY	Date of reque	st:		
Records sent:	Copies by:			
Initials: Tir	me·			
Released to:				
Patient's charge for records:				
This information was:  Hand				
☐ Hand carried by ☐ Expres	ss mailed			



Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
Consultants Laboratory
Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

#### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

(Complete in Full)

1. Name of Patient/Resident	I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my			
Street Address  City, State, Zip code  Date of Birth Phone #	authorization. I may refuse to sign this Authorization, which will not affect my abilit to obtain treatment or payment of claims. I have the right to revoke this Authorizatio by providing written notice to <u>SSM Health</u> . Revocation of this Authorization will not affect any action taken before receipt of the written revocation.			
2. I AUTHORIZE THE FOLLOWING FACILITY TO DISCLOSE THE HEALTH INFORMATION IDENTIFIED IN SECTION 5:  St. Agnes Hospital St. Francis Home Waupun Memorial Hospital Consultants Laboratory Ripon Medical Center Agnesian HealthCare Enterprises Villa Loretto Villa Rosa Christian Home & Rehabilitation Center Fond du Lac Regional Clinic, site location:	3. TO RELEASE PROTECTED HEALTH INFORMATION TO:  (If Release is to Self, State Self)  Doll and Associates  (Name of Physician/Health Care Facility/Other)  40 Camelot Drive  (Street Address)  Fond du Lac, WI 54935  (City, State, Zip code)  (920) 907-8209  (Fax number)			
Address:  Address:  PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)	For Pick-Ups, please list who will pick-up records:  Name:			
✓ Continuing Care ☐ Transferring Care ☐ Personal Use ☐ Insurance Eligibility/Benefits ☐ Disability Determination ☐ ☐ Worker's Compensation Research ☐ Other (specify):	☐ Legal Investigation ☐ Needed by/Appt. date:/			



5. HEALTH INFORMATION TO BE RELEASED	:			
☐ Office Visits ☐ Procedures	☐ Emergency Room Report	☐ Discharge Summary	☐ History & Physical Exam	Operative Reports
☐ Immunization Records ☐ Lal	b Reports			
☐ Medical Images (specify):		☐ Billing	Records (specify)	
Specific information related to:	H diagnoses, treatment plan/sumr	mary, BH assessments, psy		mary, transfer summary, psychological
·	esting, attendance history, mental :	status exam	1	
FOR THE FOLLOWING DATE(S) OR TIME FRAME  Information regarding mental heat transmitted infection, unless I limit	alth, substance use disorder, 42CFR	Part 2, AIDS or AIDS-relate	d illness, HIV/AIDS test results, de	velopmental disabilities, and/or sexually
6. Disclosure may be in the form of:	´Photocopies <b>⊴</b> Fax <b>□</b> Inspect	ion □ CD/DVD <b>☑</b> Ver	bal Disclosure 🔲 email:	
7. EXPIRATION				
This authorization will expire on	/ /	. If I do not indicate a dat	e, this will expire one (1) year fro	m the date of my signature below.
A photocopy of this authorization is as		_		, -
A photocopy of this authorization is as	vallu as tile original.			
8. SIGNATURE				
I understand that this authorization is or disclose to the persons and/or orga				on that the health care provider may use and
			Date:	
If this Authorization is signed by a rep	·			
				☐ Incompetent/Incapacitated ☐ Deceased
Legal Authority: 🖵 Legal Guardian	☐ Parent of Minor ☐ Spouse of	of Deceased	are Agent:	
☐ Personal Represe	ntative/Domestic Partner of Decea	sed 🖵 Other		
consent of the person to whom it pert	rules prohibit you from making any ains or as otherwise permitted by	y further disclosure of this 42 CFR Part 2. A general au	information unless further disclos athorization for the release of me	confidentiality rules (42 CFR Part 2 and sure is expressly permitted by the written dical or other information is NOT sufficient for atient. I understand I may inspect and receive
10. You are entitled to a copy of this auth	norization after you sign it.			
OFFICE USE ONLY	Date of reques	st:		
Records sent:	Copies by:			
Initials: Tir	me·			
Released to:				
Patient's charge for records:				
This information was:   Hand		ed first class		
☐ Hand carried by ☐ Expres	ss mailed		1	



Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
Consultants Laboratory
Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

#### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

(Complete in Full)

1.			I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this			
Name of Patient/Resident			Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my			
Street Address			authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization			
City, State, Zip code			by providing written notice to <u>SSM Health</u> . Revocation of this Authorization will not affect any action taken before receipt of the written revocation.			
Date of Birth		Phone #	-			
2. I AUTHORIZE THE FOLL IDENTIFIED IN SECTION		CLOSE THE HEALTH INFORMATION	3. TO RELEASE PROTECTED HEALTH INFORMATION TO: (If Release is to Self, State Self)			
☑ St. Agnes Hospita	ı 🗅	St. Francis Home				
Waupun Memoria	nl Hospital 🔲	Consultants Laboratory	(Name of Physician/Health Care Facility/Other)			
Ripon Medical Ce	nter 🗅	Agnesian HealthCare Enterprises	(Street Address)			
Villa Loretto		Villa Rosa	(Street Address)			
☐ Christian Home &	Rehabilitation Center		(City, State, Zip code)			
Fond du Lac Regi	onal Clinic, site location	1:				
			( Fax number)			
☐ Other:			For Pick-Ups, please list who will pick-up records:			
Address:			Name:			
			_			
4. PURPOSE OR NEED FOI	R DISCLOSURE: (Check a	applicable categories)				
☐ Continuing Care	,					
	_	enefits  Disability Determination	☐ Legal Investigation ☐ Needed by/Appt. date: / /			
☐ Worker's Compens			MM DD YYYY			
- Worker 5 compens	adon Research	and openly).	<del></del>			



5. HEALTH INFORMATION TO BE RELEASED	:			
☐ Office Visits ☐ Procedures	☐ Emergency Room Report	☐ Discharge Summary	☐ History & Physical Exam	Operative Reports
☐ Immunization Records ☐ Lal	Reports			
☐ Medical Images (specify):		Billing	Records (specify)	
✓ Specific information related to: C	ontinuing Care Plan Discharge Pa	acket (History & Physical,	Continuing Care Plan, Patient Disch	narge Instructions and Discharge Summary)
FOR THE FOLLOWING DATE(S) OR TIME FRAM				
☑ Information regarding mental hea		art 2, AIDS or AIDS-related	illness, HIV/AIDS test results, dev	elopmental disabilities, and/or sexually
6. Disclosure may be in the form of: $\Box$	Photocopies	ın □ CD/DVD □ Verl	oal Disclosure 🔲 email:	
7. <b>EXPIRATION</b> This authorization will expire on	J	. If I do not indicate a date	, this will expire one (1) year fron	n the date of my signature below.
A photocopy of this authorization is as				
8. SIGNATURE I understand that this authorization is or disclose to the persons and/or orga				on that the health care provider may use and
Signature:			_ Date:	
If this Authorization is signed by a rep	resentative on behalf of the patient,	, complete the following:		
Representative's Name (please print):			Patient is: 🗖 Minor 🗆	Incompetent/Incapacitated 🖵 Deceased
Legal Authority: 🗖 Legal Guardian	☐ Parent of Minor ☐ Spouse of	Deceased	re Agent:	
☐ Personal Represe	ntative/Domestic Partner of Decease	ed 🗖 Other		
consent of the person to whom it pert	ules prohibit you from making any f ains or as otherwise permitted by 42	further disclosure of this in 2 CFR Part 2. A general aut	nformation unless further discloss thorization for the release of med	onfidentiality rules (42 CFR Part 2 and ure is expressly permitted by the written ical or other information is NOT sufficient for stient. I understand I may inspect and receive
10. You are entitled to a copy of this auth	orization after you sign it.			
OFFICE USE ONLY Records sent: Initials: Date: Tir Released to: Patient's charge for records:	Copies by:			
This information was: ☐ Hand © Hand carried by ☐ Expres	carried by patient	d first class		



Agnesian HealthCare Enterprises
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Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

(Complete in Full)

				` '		,				
1.					- 11	I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this				
Name o	Name of Patient/Resident  Street Address					Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining m				
Street						authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization				
City, State, Zip code					III .	by providing written notice to <u>SSM Health</u> . Revocation of this Authorization will not affect any action taken before receipt of the written revocation.				
Date of	Birth			Phone #						
	UTHORIZE T		TO DIS	CLOSE THE HEALTH INFORMATION	3.	TO RELEASE PROTECTED HEALTH INFORMATION TO: (If Release is to Self, State Self)				
	St. Agnes	Hospital		St. Francis Home						
	Waupun	Memorial Hospital		Consultants Laboratory		(Name of Physician/Health Care Facility/Other)				
	Ripon Me	dical Center		Agnesian HealthCare Enterprises		(Street Address)				
	Villa Lore	tto		Villa Rosa		(Street Audiess)				
	Christian	Home & Rehabilitation	Center			(City, State, Zip code)				
	Fond du l	ac Regional Clinic, site I	ocation	<u>:</u>						
						( Fax number)				
4	Other: _	Agnesian HealthCa	are, Ou	tpatient Behavioral Health		For Pick-Ups, please list who will pick-up records:				
	Address:	430 E. Division Stre	eet	Phone: (920) 926-4390		Name:				
		Fond du Lac, WI 54	1935	Fax: (920) 926-8933						
		IEED FOR DISCLOSURE: (		pplicable categories)						
T	Continuing	Care   Transferring	Care							
	Personal U	se 🔲 Insurance Eligii	bility/B	enefits 🗖 Disability Determination 🕻	<b>□</b> Legal	Investigation   Needed by/Appt. date:///  MM DD YYYY				
	Worker's C	ompensation Research	<b></b> 0	ther (specify):		וווו שט ויווי				



☐ Other:\_

Fax form to: ROI: (920) 926-8910 Medical Imaging (Films): (920) 926-4868

# **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)**

5. HEALTH INFORMATION TO BE RELEASED:	:			
☐ Office Visits ☐ Procedures	☐ Emergency Room Report	☐ Discharge Summary	☐ History & Physical Exam	Operative Reports
☐ Immunization Records ☐ Lab	Reports			
☐ Medical Images (specify):			Records (specify)	
			chotherapy notes, discharge sum	mary, transfer summary, psychological
TO FOR THE FOLLOWING DATE(S) OR TIME FRAMI	sting, attendance history, mental E: From: /		1 1	
	lth, substance use disorder, 42CFR	Part 2, AIDS or AIDS-related	d illness, HIV/AIDS test results, de	velopmental disabilities, and/or sexually
6. Disclosure may be in the form of:	Photocopies <b>S</b> Fax Inspec	tion 🗖 CD/DVD 🗹 Ver	bal Disclosure 🖵 email:	
7. EXPIRATION				
This authorization will expire on		If I do not indicate a date	e, this will expire one (1) year from	m the date of my signature below.
A photocopy of this authorization is as				
8. SIGNATURE				
				on that the health care provider may use and
Signature:			_ Date:	
If this Authorization is signed by a repr	esentative on behalf of the patie	nt, complete the following:		
Representative's Name (please print):			Patient is: 🖵 Minor 🗆	☐ Incompetent/Incapacitated ☐ Deceased
Legal Authority: 🗖 Legal Guardian	☐ Parent of Minor ☐ Spouse	of Deceased 🔲 Health Ca	are Agent:	
☐ Personal Represer	ntative/Domestic Partner of Decea	ased 🗅 Other		
consent of the person to whom it perto	ules prohibit you from making an ains or as otherwise permitted by	y further disclosure of this i 42 CFR Part 2. A general au	nformation unless further disclos thorization for the release of med	confidentiality rules (42 CFR Part 2 and ure is expressly permitted by the written dical or other information is NOT sufficient for atient. I understand I may inspect and receive
10. You are entitled to a copy of this auth	orization after you sign it.			
OFFICE USE ONLY	Date of reque	st:		
Records sent:	•			
Initials:				
Date: Tim				
Patient's charge for records:				
This information was: ☐ Hand of		ed first class		<del></del>
☐ Hand carried by ☐ Expres	ss mailed			



Agnesian HealthCare Enterprises
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Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

(Complete in Full)

				` '		,				
1.					- 11	I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this				
Name	Name of Patient/Resident  Street Address					Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my				
Street						authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization				
City, State, Zip code					- 11	by providing written notice to <u>SSM Health</u> . Revocation of this Authorization will not affect any action taken before receipt of the written revocation.				
Date o	f Birth		_	Phone #						
		THE FOLLOWING FACILITY I SECTION 5:	TO DIS	CLOSE THE HEALTH INFORMATION	3.	TO RELEASE PROTECTED HEALTH INFORMATION TO: (If Release is to Self, State Self)				
	St. Agne	s Hospital		St. Francis Home						
	l Waupun	Memorial Hospital		Consultants Laboratory		(Name of Physician/Health Care Facility/Other)				
	Ripon M	edical Center		Agnesian HealthCare Enterprises		(Street Address)				
	l Villa Lore	etto		Villa Rosa						
	1 Christian	n Home & Rehabilitation (	Center			(City, State, Zip code)				
	Fond du	Lac Regional Clinic, site I	ocation	:						
						( Fax number)				
V	Other: _			l Outpatient Behavioral Health		For Pick-Ups, please list who will pick-up records:				
	Address	620 W. Brown Street		Phone: (920) 324-7600		Name:				
		Waupun, WI 53963		Fax: (920) 324-8459						
	_	NEED FOR DISCLOSURE: (		pplicable categories)						
		g Care   Transferring								
	I Personal I	Use 🔲 Insurance Eligil	oility/B	enefits  Disability Determination	☐ Legal	Investigation    Needed by/Appt. date:    MM   DD     YYYY				
	Worker's	Compensation Research	<b>0</b>	ther (specify):						



5. HEALTH INFORMATION TO BE RELEASED:	
□ Office Visits □ Procedures □ Emergency Room Report □ Discharge Summary □ Histor	y & Physical Exam
☐ Immunization Records ☐ Lab Reports	
☐ Medical Images (specify): ☐ Billing Records (specify)	ify)
Specific information related to:  BH diagnoses, treatment plan/summary, BH assessments, psychotherapy no	otes, discharge summary, transfer summary, psychological
testing, attenuance mistory, mental status exam	1
FOR THE FOLLOWING DATE(S) OR TIME FRAME: From:/	
Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/intransmitted infection, unless I limit the disclosure to exclude the following:	
<b>6. Disclosure may be in the form of:</b> ✓ Photocopies ✓ Fax ☐ Inspection ☐ CD/DVD ✓ Verbal Disclosure	☐ email:
7. EXPIRATION	
This authorization will expire on/	pire one (1) year from the date of my signature below.
A photocopy of this authorization is as valid as the original.	
Tiphotocopy of this dation satisfies as the original.	
<b>8. SIGNATURE</b> I understand that this authorization is voluntary. I understand that there may be a charge for copies. I am confirm	ning my authorization that the health care provider may use and
or disclose to the persons and/or organizations named in this form the protected health information described in	
Signature: Date:	
If this Authorization is signed by a representative on behalf of the patient, complete the following:	
Representative's Name (please print): Pati	ent is: 🗖 Minor 💢 Incompetent/Incapacitated 📮 Deceased
Legal Authority: Legal Guardian Parent of Minor Spouse of Deceased Health Care Agent: _	
☐ Personal Representative/Domestic Partner of Deceased ☐ Other	
9. Prohibition of Disclosure for Substance Use Disorder: This information has been disclosed to you from records polymers. Wisconsin Statute 51.30). The Federal rules prohibit you from making any further disclosure of this information used the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcoacopy of the disclosed information.	nless further disclosure is expressly permitted by the written r the release of medical or other information is NOT sufficient for
10. You are entitled to a copy of this authorization after you sign it.	
OFFICE USE ONLY Date of request:	7
Records sent:Copies by:	
Initials:	
Date: Time:   Released to:	
Patient's charge for records:	
This information was:   Hand carried by patient   Mailed first class	
☐ Hand carried by ☐ Express mailed ☐ Fax	
□ Other:	



Agnesian HealthCare Enterprises
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St. Francis Home
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#### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

(Complete in Full)

Name of Patient/Resident	I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further		
Street Address  City, State, Zip code  Date of Birth Phone #	used or released by persons or organizations receiving it without obtaining m authorization. I may refuse to sign this Authorization, which will not affect my abilit to obtain treatment or payment of claims. I have the right to revoke this Authorization by providing written notice to <a href="SSM Health">SSM Health</a> . Revocation of this Authorization will not affect any action taken before receipt of the written revocation.		
2. I AUTHORIZE THE FOLLOWING FACILITY TO DISCLOSE THE HEALTH INFORMATION IDENTIFIED IN SECTION 5:  St. Agnes Hospital St. Francis Home Consultants Laboratory Ripon Medical Center Agnesian HealthCare Enterprises Villa Loretto Villa Rosa Christian Home & Rehabilitation Center Fond du Lac Regional Clinic, site location:	3. TO RELEASE PROTECTED HEALTH INFORMATION TO:  (If Release is to Self, State Self)  Waupun Memorial Hospital Outpatient Behavioral Health  (Name of Physician/Health Care Facility/Other)  620 W. Brown Street  (Street Address)  Waupun, WI 53963  (City, State, Zip code)  Fax: (920) 324-8459  (Fax number)		
Other:Address:	For Pick-Ups, please list who will pick-up records:  Name:		
4. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)  ☐ Continuing Care ☐ Transferring Care ☐ Personal Use ☐ Insurance Eligibility/Benefits ☐ Disability Determination ☐ ☐ Worker's Compensation Research ☐ Other (specify):	□ Legal Investigation □ Needed by/Appt. date://		



5. HEALTH INFORMATION TO BE RELEASED	:			
☐ Office Visits ☐ Procedures	☐ Emergency Room Report	☐ Discharge Summary	☐ History & Physical Exam	Operative Reports
☐ Immunization Records ☐ Lal	b Reports			
☐ Medical Images (specify):		☐ Billing	Records (specify)	
Specific information related to:	H diagnoses, treatment plan/sum	ımary, BH assessments, psy		mary, transfer summary, psychological
te	esting, attendance history, mental	status exam	1	
FOR THE FOLLOWING DATE(S) OR TIME FRAM				
Information regarding mental heat transmitted infection, unless I limit				elopmental disabilities, and/or sexually
6. Disclosure may be in the form of:	Photocopies Fax Inspec	tion 🗖 CD/DVD 🗹 Ver	bal Disclosure 🔲 email:	
7. EXPIRATION				
This authorization will expire on		If I do not indicate a dat	e, this will expire one (1) year from	n the date of my signature below.
A photocopy of this authorization is as				
8. SIGNATURE				
I understand that this authorization is or disclose to the persons and/or orga				on that the health care provider may use and
If this Authorization is signed by a rep				
Representative's Name (please print):	•	, ,	Patient is: ☐ Minor ☐	☐ Incompetent/Incapacitated ☐ Deceased
Personal Represe	ntative/Domestic Partner of Decea	ased • Other		
consent of the person to whom it pert	rules prohibit you from making an ains or as otherwise permitted by	ny further disclosure of this i v 42 CFR Part 2. A general au	information unless further disclos thorization for the release of med	confidentiality rules (42 CFR Part 2 and ure is expressly permitted by the written lical or other information is NOT sufficient for atient. I understand I may inspect and receive
10. You are entitled to a copy of this auth	norization after you sign it.			
OFFICE USE ONLY	Date of reque	st:		
Records sent:	Copies by:			
Initials:	mo:			
Date: Tir	IIG			
Patient's charge for records:				
This information was:	carried by patient 🔲 Maile	ed first class		p=-1,
☐ Hand carried by ☐ Expres	ss mailed			

