

LABEL

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

 Street Address

 City, State, Zip code

_____ _____
 Date of Birth Phone #

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 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 by providing written notice to SSM Health. 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:

- | | |
|--|--|
| <input type="checkbox"/> St. Agnes Hospital | <input type="checkbox"/> St. Francis Home |
| <input type="checkbox"/> Waupun Memorial Hospital | <input type="checkbox"/> Consultants Laboratory |
| <input type="checkbox"/> Ripon Medical Center | <input type="checkbox"/> Agnesian HealthCare Enterprises |
| <input type="checkbox"/> Villa Loretto | <input type="checkbox"/> Villa Rosa |
| <input type="checkbox"/> Christian Home & Rehabilitation Center | |
| <input type="checkbox"/> Fond du Lac Regional Clinic, site location: | |

Other: _____
 Address: _____

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:

(If Release is to Self, State Self)

 (Name of Physician/Health Care Facility/Other)

 (Street Address)

 (City, State, Zip code)

 (Fax number)

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 Legal Investigation Needed by/Appt. date: _____ / _____ / _____
MM DD YYYY
- Worker's Compensation Research Other (specify): _____

(CONTINUED ON BACK)



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 FRAME: From: ____/____/____ to: ____/____/____
MM DD YYYY MM DD YYYY

- Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. Disclosure may be in the form of: Photocopies
 Fax
 Inspection
 CD/DVD
 Verbal Disclosure
 email: _____

7. EXPIRATION

This authorization will expire on ____/____/____. If I do not indicate a date, this will expire 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 confirming 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 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): _____ Patient 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 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.

10. You are entitled to a copy of this authorization after you sign it.

<p>OFFICE USE ONLY</p> <p>Records sent: _____ Copies by: _____</p> <p>Initials: _____</p> <p>Date: _____ Time: _____</p> <p>Released to: _____</p> <p>Patient's charge for records: _____</p> <p>This information was: <input type="checkbox"/> Hand carried by patient <input type="checkbox"/> Mailed first class <input type="checkbox"/> Hand carried by <input type="checkbox"/> Express mailed <input type="checkbox"/> Fax <input type="checkbox"/> Other: _____</p> <p>Fax form to: <input type="checkbox"/> ROI: (920) 926-8910 <input type="checkbox"/> Medical Imaging (Films): (920) 926-4868</p>	<p>Date of request: _____</p>
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