LABEL

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION AGNESIAN HEALTHCARE

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

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

Ripon Medical Center
845 Parkside Street
Ripon, WI 54971

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 ❑ exchanged with

❑ mail ❑ pick-up - date: ______________________

❑ Password (hospital use): ______________________

____
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 Fax number

FOR PICK-UPS, PLEASE LIST WHO WILL PICK-UP RECORDS:

____
Name

3. PROVIDER USE – For Referral Purpose complete the following:

Diagnosis: ______________________________

Provider: ______________________ Department: ______________________

❑ Froedtert ❑ Children's Hospital of WI ❑ UW-Madison ❑ Other: ______________________

Check to send last results of:

- ❑ Provider Notes ______________________
- ❑ Labs ______________________
- ❑ Medical Imaging Report ❑ CD ❑ ______________________
- ❑ Pathology ______________________
- ❑ Cardiology Studies (EKG/Echo/Stress Test) ______________________
- ❑ Specify other notes: ______________________

4. 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

❑ Fond du Lac Regional Clinic, site location: ______________________

❑ Other: ______________________

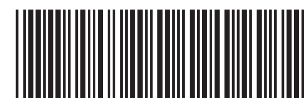
______________________ ______________________
Street City, State, Zip Code

(CONTINUED ON BACK)

Fax form to:

❑ ROI: (920) 926-8910

❑ Medical Imaging (Films): (920) 926-4868


MR-0465

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5. **Specific type of health information to be disclosed:**
❑ All health records (last 2 years) ❑ Progress Notes ❑ Discharge Summary ❑ Medications
❑ History & Physical ❑ Therapy Notes ❑ Outpatient Report ❑ Condition Updates
❑ Lab Reports ❑ Vision Records ❑ Immunization Record
❑ Medical Imaging: ❑ Other (specify): ______________________________
❑ CD ❑ Reports ❑ Echo ______________________________

Health information protected by federal confidentiality rules (42CRF part 2)
❑ BH Diagnoses ❑ BH Mental status exam ❑ BH Attendance ❑ Psychological testing
❑ Drug/alcohol history ❑ BH Physical exam ❑ Psychiatric history ❑ BH Medication management
❑ BH Treatment summary or plan ❑ BH Initial intake/assessment ❑ BH Discharge/summary transfer ❑ Psychotherapy notes
❑ AODA ❑ Hepatitis B ❑ AIDS (acquited immune deficiency syndrome)
❑ HIV infection ❑ TB (tuberculosis) ❑ STD (sexually transmitted disease(s) ❑ Sickle cell anemia
❑ Other: ______________________________

6. **Date(s) of health information to be disclosed and/or chronic condition:** ______________________________

______________________________ ______________________________

______________________________ ______________________________

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

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

9. **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 Health Information Management 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.

10. **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.**

11. **Signature of Patient:** ______________________________ **Date & Time Signed:** ________________

12. **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 to sign: ______________________________ **Date:** ________________ **Time:** __________

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
❑ Hand carried by ❑ Mailed first class
❑ Express mailed ❑ Fax
❑ Other: ______________________________

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