

Medical Record Number _____

Home Phone: _____

Date of Birth: _____

 Patient Name: _____

Last
First
Middle
Maiden/Other

Address _____ City _____ State _____ Zip _____

- I authorize and give permission for:
- PHC, Oconomowoc Memorial Hospital (262) 569-0258
 - PHC, Waukesha Memorial Hospital (262) 928-2580
 - PHCMA - Name Clinic _____
 - Organization/Individual _____

- To release information to:
- PHC, Oconomowoc Memorial Hospital
 - PHC, Waukesha Memorial Hospital
 - PHCMA - Name Clinic _____
 - Organization/Individual _____

Other Health Care Facility, include address _____

Street Address _____
 City _____ State _____ Zip _____
 Fax Number _____ Other _____
(Physician Office Only)

I understand that authorizing the release of this protected health information (PHI) is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, enrollment, or eligibility for benefits. I understand that any release of PHI carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

I fully understand that my PHI in connection with the services date(s) stated below may include reference to treatment of alcohol and drug abuse, psychiatric care, developmental disabilities, HIV test results/acquired immune deficiency syndrome, intoxication tests and/or fetal monitor tracings. Unless otherwise revoked, this authorization will expire on the following date or event: _____
 If I fail to specify an expiration date or event, this authorization will expire six months from the date signed.

<p>PHI to be released: Date(s) of service From from _____ to _____</p> <ul style="list-style-type: none"> <li style="width: 50%;"><input type="checkbox"/> Ambulance Record <li style="width: 50%;"><input type="checkbox"/> Pathology Report <li style="width: 50%;"><input type="checkbox"/> Cardiac Studies <li style="width: 50%;"><input type="checkbox"/> Progress Notes <li style="width: 50%;"><input type="checkbox"/> Consultation <li style="width: 50%;"><input type="checkbox"/> Radiology Films <li style="width: 50%;"><input type="checkbox"/> Disability Records <li style="width: 50%;"><input type="checkbox"/> Radiology Reports <li style="width: 50%;"><input type="checkbox"/> Discharge Summary <li style="width: 50%;"><input type="checkbox"/> Rehab/Therapy Notes <li style="width: 50%;"><input type="checkbox"/> Electrocardiograms (EKG) <li style="width: 50%;"><input type="checkbox"/> Specify other records: <li style="width: 50%;"><input type="checkbox"/> Emergency Room Report <li style="width: 50%;"><input type="checkbox"/> 8 x 10 film <li style="width: 50%;"><input type="checkbox"/> History & Physical <li style="width: 50%;"><input type="checkbox"/> 10 x 12 film <li style="width: 50%;"><input type="checkbox"/> Immunization Records <li style="width: 50%;"><input type="checkbox"/> 14 x 17 film <li style="width: 50%;"><input type="checkbox"/> Laboratory Reports <li style="width: 50%;"><input type="checkbox"/> Image CD _____ <li style="width: 50%;"><input type="checkbox"/> Operative Report <li style="width: 50%;"><input type="checkbox"/> Other _____ 	<p>The reason of this release is: (Check one/more of the following)</p> <ul style="list-style-type: none"> <li style="width: 50%;"><input type="checkbox"/> Continued Medical Care <li style="width: 50%;"><input type="checkbox"/> Legal Investigation <li style="width: 50%;"><input type="checkbox"/> Disability Determination <li style="width: 50%;"><input type="checkbox"/> Payment of Claim/Benefits <li style="width: 50%;"><input type="checkbox"/> Insurance Application <li style="width: 50%;"><input type="checkbox"/> Personal Use <li style="width: 50%;"><input type="checkbox"/> Insurance Filing <li style="width: 50%;"><input type="checkbox"/> Workman's Comp <li style="width: 50%;"><input type="checkbox"/> Other, please specify _____ <p>I understand that a photocopy shall be considered as valid as the original. I may inspect and arrange for photocopies of the information that is to be disclosed with the Health Information Management (HIM) department. I understand that I have a right to cancel this authorization at any time by providing written notice to HIM department. I understand that the cancellation will not apply to information that has already been released in response to this authorization. I understand that cancellation will not apply to my insurance company as needed to contest a claim under my policy.</p>
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- In compliance with Wisconsin Statutes which require special permission to release the below PHI, please release records pertaining to:
- Alcohol/Drug Treatment Records
 - HIV test results, AIDS or AIDS-Related disease
 - SANE Photos
 - Drug Abuse or test results
 - Mental Health Records
 - Sexually Transmitted Disease
 - Developmental Disabilities
 - SANE Documents
 - Other _____

Re-Release: I agree that re-release of PHI from: PHC Oconomowoc Memorial Hospital PHC Waukesha Memorial Hospital

PHCMA Clinic (name) _____ Other: _____

can be made to: PHC Oconomowoc Memorial Hospital PHC Waukesha Memorial Hospital

PHCMA Clinic (name) _____

Other: _____

Name _____	Address _____	City _____	State _____	Zip _____
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Check one: verbal release paper release electronic/digital release (if system cannot create or transmit electronic format, a written explanation will be provided along with paper copies of the requested information)

Release by: ___ US Mail ___ Pick-Up: Location _____

Signature of Patient: _____	Date: _____	Time: _____	
Signature of Guardian or or Legal Representative: _____ <small>(State relationship to patient)</small>	Date: _____	Time: _____	
Signature of Witness: _____	Date: _____	Time: _____	
To be signed <u>only</u> if patient cannot sign.			
Information Released By: _____	Date: _____	Time: _____	
Signature of person releasing information: _____	Unit _____	Ext. _____	

This form meets requirements as defined in WI Statutes 146.81-83, 51.30, 252.15, and Federal Regulations 42CFR2 and 45CFR164.508, 164.508(a), 45CFR (Part 5b)

Provide a copy of this completed form to the signing individual.

OFFICE USE ONLY:
 Requested by: _____ Info released by: _____ Date picked up/released: _____

ReRelease authorized by patient contact. Initials: _____ Date _____ Time _____

PATIENT LABEL