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# Authorization for Release of Protected Health Information (PHI)

Contact Information for Release of Information

Tel#: (608) 637-4332 | Fax#: (608) 637-4288

Patient: _____ Date of Birth: _____

Street Address: _____ Telephone: _____

City: _____ State: _____ Zip code: _____

## Authorizes Release of Information

FROM:

_____
Name

_____
Street Address

_____
City, State, Zip

TO:

_____
Name

_____
Street Address

_____
City, State, Zip

Authorizes Verbal exchange of information: ☐ Yes ☐ No

## Type or extent of PHI to be released: (Check all applicable categories)

___ Medical/Dental records (history, examination, reports, Progress notes, med list, etc.)
___ Lab Reports ___ X-Ray Reports
___ Operation Reports ___ Prescriptions ___ ER Reports
___ Cardiopulmonary Diagnostic & Rehab Reports ___ Consultations ___ Billing records
___ Therapy Records (physical, occupational, speech ___ Other: _____

Release above records from: _____ (date) to: _____ (date).

Format for Records: ☐ Paper ☐ CD ☐ MyCare (patient portal) ☐ Fax Records (fax # _____)
☐ Email (secure format)

## In Compliance with WI Statutes, which require special permission to release otherwise privileged information please release records pertaining to:

___ Developmental Disability Records ___ Sexually Transmitted Disease Records ___ HIV Test Results
___ Mental Health Consults/Records/Meds ___ Alcohol & Drug Abuse Records

Release above records from: _____ (date) to _____ (date).

## Purpose for need for disclosure: (Check all applicable categories)

___ Further Medical care ___ Coordinating Care for Dependent/Spouse
___ Insurance Eligibility/Benefits ___ Claims Resolution
___ Plan of care/Treatment Decisions ___Other: _____

## Your Rights with Respect to this Authorization:

Right to Receive Copy of this Authorization: I understand that if I signed this form I have a right to inspect and receive a copy of the records being requested. Right to Refuse to Sign this Authorization: I understand that I am under no obligation to sign this form and that Vernon Memorial Healthcare may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care benefits that is solely for the purpose of creating PHI for disclosure to a third party. Right to withdraw this Authorization: I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Vernon Memorial Healthcare. This withdrawal will not be effective regarding the uses/disclosures of information that VMH has made prior to receipt of your withdrawal. HIV Test Results: I understand my HIV test results may be released without authorization to persons/organizations that have access under State Law and a list of those persons/organizations is available upon request. WI Statutes 51.30 and 252.15 for HIV, Mental Health, etc. requires patient authorization to disclose health information for payment purposes.

Redisclosure Notice: Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and would no longer be protected by this authorization. I understand that any disclosure of information carries the potential for an unauthorized re-disclosure, especially if the information is no longer protected by Federal or State privacy standards.

Generally, all patients 18 years and older must sign for the disclosure of information, unless one of the following conditions apply:

- The patient is incompetent.
- The patient is incapacitated and unable to sign the form.
- The patient is deceased (the surviving spouse or legal representative must sign authorization releasing records of deceased patient).

Mental Health Records:
Wisconsin Law: All patients 14 years of age and older may sign for disclosure of patient information involving treatment for mental illness or developmental disabilities. Parents generally may also consent, unless denied physical placement of the patient. When a parent consents for a patient 14 years of age or older, it is recommended that the patient sign also. Alcohol & Drug Abuse Treatment Records:
Wisconsin Law: Patients 12 years of age or older must sign for the disclosure of alcohol and drug abuse records unless the treating provider determines and documents that the minor is not capable.

All persons signing for the disclosure of records, instead of the patient, must state their relationship to the patient and have available proof of legal authority to authorize the disclosure.

Expiration Date: This authorization is valid for 1 year from the date of signature or until _____ (specific date up to 2 years) and covers records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed, up until the expiration date.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient/Legal Representative | Authorizing Date | Time |

(If signed by person other than patient, state relationship to patient)

Patient is: _____ Minor ____ Incompetent _____ Deceased

Legal Authority: _____ Parent or Legal Guardian _____ Next of Kin of Deceased

| _____ | _____ | _____ |
|---|---|---|
| Signature of Person Releasing Information | Date of Release | Time |

This release is executed in conformity with State and Federal Privacy Laws.

Office Use Only: _____ Pick Up _____ Mail _____ Fax _____ CD