Marshfield Medical Center

Patient name			FIN
MHN	DOB	Age	Gender

Protected Health Information Disclosure – Beaver Dam

Release of Information Authorization

Facility: ☐ Beaver Dam ☐ Eau Claire ☐ Ladysmith ☐ Marshfield ☐ Minocqua ☐ Neillsville ☐ Rice Lake ☐ Wausau ☐ _____

Patient Information

Name of patient/previous names

Street address | City | State | ZIP

Authorizes disclosure by:

Marshfield Medical Center – Beaver Dam

707 South University Avenue
Beaver Dam, Wisconsin 53916

Phone: 920-887-4064

Facsimile: 920-887-6691

Disclosure of health information to:

☐ Marshfield Clinic Health System ***OR***

Name of person or organization(s)

Street address

City, state, ZIP

Information to be disclosed *(provide specific purpose for disclosure or check applicable category)*

☐ Discharge summary ☐ History and physical ☐ Radiology images ☐ Operative report
☐ Pathology report ☐ Consultation ☐ Laboratory report ☐ Rehab notes
☐ ED report ☐ Radiology report ☐ Other _____

Disclosures requiring special consent

In compliance with Wisconsin Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply.

☐ HIV/AIDS* ☐ Mental/Behavioral health conditions ☐ Drug/Alcohol abuse/treatment

***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.

For the following dates

From (date – month/day/year) _____ /_____ /_____ To (date – month/day/year) _____ /_____ /_____

Purpose for disclosure *(provide specific purpose for disclosure or check applicable category)*

☐ Continuing care ☐ Disability determination ☐ Insurance/Claim purposes ☐ Legal investigation
☐ Personal use ☐ Vocational rehab eval. ☐ Workers' Compensation
☐ Other _____

 © 2020 Marshfield Clinic Health System

Marshfield Medical Center

Patient name			
MHN	DOB	Age	Gender

Protected Health Information Disclosure – Beaver Dam

Release of Information Authorization (Continued)

Your rights with respect to this authorization

Right to inspect or receive a copy of the health information to be used or disclosed – I understand that I have the right to inspect or receive a copy (at a reasonable fee) of the health information I have authorized to be used or disclosed by this authorization form.

Right to receive copy of this authorization – I understand that if I agree to sign this authorization, I must be provided with a copy.

Right to refuse to sign this authorization – I understand that I am under no obligation to sign this form and that Marshfield Medical Center 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 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 to Marshfield Medical Center Health Information Management Department. I am aware that my withdrawal will not be effective until received by the organization and will not be effective regarding the uses and/or disclosures of my health information that the organization has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards.

****WI Statutes 51.30 and 252.15** requires patient authorization to disclose health information for payment purposes.

Expiration date

This authorization is good until the following date(s) _____ or for 1 year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____	_____	_____ / _____ / _____	_____
Patient signature (Patient's legal representative)	(Relationship)	Date (month/day/year)	Time

Method by which patient's/legal representative's identity was confirmed

☐ Government issued photo identification ☐ Other _____

For office use only

Date received	Date disclosed	Processed by	☐ Mailed ☐ Faxed ☐ Picked up by _____

 © 2020 Marshfield Clinic Health System