



Patient Name:

MRN:

DOB:

Sex:

## Release of Information Authorization

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<b>1. Patient Information</b>	<b>Name:</b>		Date of Birth	
	Address			
	City		State	ZIP
<b>2. Health Care Provider of Facility who has the information you want released</b>	<b>Marshfield Clinic Health System - All Locations</b> (excluding Family Health Center - all locations) <b>OR</b>			
	<b>Name/Organization:</b>			
	Address			
	City		State	ZIP
<b>3. Where you want the information to be sent</b>	<b>Name/Organization:</b>		Attention	
	Phone #		Fax #	
	Address			
	City		State	ZIP
<b>4. Why the information is needed</b>	Continuing Care      Worker's Compensation      School      Personal Use      Legal Insurance Application      Insurance payment/claim      Form Completion (FMLA/Disability, ect.) Other _____			
<b>5. What information you want released</b>  Complete sections A, B, C,D or E. Do <b>NOT</b> complete all of them  **Choose section B for records normally needed by healthcare providers  Complete section D if you have records in any of these categories  Complete section E if you are a minor authorizing disclosure of these protected records	<b>A. <u>Service Dates:</u></b> Between _____ to _____ <b>Specific Diagnosis or Provider</b> _____			
	<b>B. <u>Send All Routine Records:</u></b> Clinic Notes, History and Physical, Discharge Summary, Consult Report, Emergency Room Report, Operative Report, Lab, Urgent Care Report, Radiology, Procedure notes, Diagnostic Test Results			
	<b>C. <u>Select the Specific Records to Release:</u></b>			
	Discharge Summary      Diagnostic Test Results      Pathology Reports History and Physical Exams      Rehab Reports (PT/OT/Speech)      Clinic Notes Operative/Procedure Reports      Medication List      Laboratory Reports Consultation Reports      Radiology Reports      Emergency Room/Urgent Care Report Billing Records      FMLA/Disability/Other Form      Other _____			
	<b>D. <u>Records Requiring Specific Consent:</u></b> <b>The applicable records must be checked in order to be released</b> Psychological Testing Mental Health Treatment Notes AODA Treatment Notes Neuropsychology Notes HIV/AIDS Results Genetic Testing Results		<b>E. <u>Records Requiring Minor Consent:</u> <i>The applicable records must be checked &amp; signed in order to be released</i></b> OutpatientAODA (12+yrs) InpatientAODA - Detox Only (12+yrs) <input type="checkbox"/> Pregnancy test (17 yrs or younger) Outpatient mental health care (14+yrs)      Birth control pills (17 yrs or younger) Inpatient mental health care (14+yrs)      Pregnancy-related care or care of newborn (17 yrs or younger) Neuropsychology notes (14+yrs)      HIV/AIDS test results (14+yrs) Rape or sexual assault/abuse (12+yrs) Sexually transmitted disease (17+yrs)	
		Patient signature _____ Date/Time _____		

Patient Name: _____		MRN: _____	DOB: _____	Sex: _____
<b>5. What information you want released (continued)</b> <i>Complete section F if need any of these records</i>	<b>F. <u>Radiology Films, Pathology Slide or Photographs</u></b> <b>**All loaned films &amp; slides must be returned within 30 days**</b> Radiology Images: _____ Pathology slides: _____ Photographs (define type): _____ Date Mailed: _____ Date Picked Up: _____ By _____			
<b>6. When information is needed by</b>	Date information is needed: _____ or Date of the Appointment: _____ To check on the status of your request: call 1-800-782-8581, Ext. 93676, option 3 or email <a href="mailto:medicalrecords@marshfieldclinic.org">medicalrecords@marshfieldclinic.org</a> To check on the status of FMLA/Disability/Other Form: call 1-800-782-8581, Ext. 93676, option 2 or email <a href="mailto:disability@marshfieldclinic.org">disability@marshfieldclinic.org</a>			
<b>7. How would you like this information?</b>	<b><u>Release Method/Format Requested:</u></b> <i>Note: Information supplied electronically is in PDF format and is encrypted</i> Mailed      Faxed      USB drive      CD/DVD      Email: _____ Other: _____			
<b>8. Expiration</b>	This authorization is effective for <b>one year</b> after the date of signature unless otherwise indicated _____			

Patient Signature \_\_\_\_\_

Date/Time \_\_\_\_\_

Printed Name \_\_\_\_\_

Signature of Authorized Person \_\_\_\_\_

Date/Time \_\_\_\_\_

(Relationship) \_\_\_\_\_

Printed name \_\_\_\_\_

Parent of Minor

Court appointed guardian/conservator - include legal documentation

**Wisconsin Authorizations:**

**Mail Form to:** MCHS, 1000 North Oak Avenue, Marshfield, WI 54449  
 ATTN: Health Information Management, 1N

**Fax Form to:** 715-221-6992

**Email Form to:** [medicalrecords@marshfieldclinic.org](mailto:medicalrecords@marshfieldclinic.org)

**Wisconsin - FMLA/Disability/Other Form Authorizations:**

**Mail Form to:** MCHS, 1000 North Oak Avenue, Marshfield, WI 54449  
 ATTN: Health Information Management, HM2

**Fax Form to:** 715-221-5847

**Email Form to:** [disability@marshfieldclinic.org](mailto:disability@marshfieldclinic.org)

**Michigan Authorizations:**

**Mail Form to:** MMC-Dickinson, 1712 S. Stephenson St, Iron Mtn, MI 49801  
 ATTN: Health Information Management - ROI

**Fax Form to:** 906-221-6992

**Email Form to:** [medicalrecords@marshfieldclinic.org](mailto:medicalrecords@marshfieldclinic.org)

Patient Name:	MRN:	DOB:	Sex:
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**Redisclosure notice to patient:** If the person(s) and/or organization(s) listed on the front side are not health care providers, health care clearinghouses, or health plans, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose your health information.

**Disclosure notice to recipient of patient health care records:** Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

**Disclosure notice to recipient of mental health, alcohol and/or drug treatment records:** This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**Your rights with respect to this authorization**

- *Right to receive copy of this authorization* – You have the right to receive a copy of this authorization.
- *Right to refuse to sign this authorization* – You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding:
  - research-related treatment
  - health plan enrollment or eligibility
  - the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party
- *Right to withdraw this authorization* – You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact the Health Information Management (medical records) department. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have made prior to the receipt of your cancellation form. You understand that 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 policy or the policy itself.
- *Right to inspect a copy of the health information to be used or disclosed* – You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form. You may arrange to inspect your health information or obtain copies of your health information by contacting the Health Information Management (medical records) department.
- *HIV test results* – Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- *Mental health treatment records* – You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.