Marshfield Clinic Health System

Clear Form

| Patient Name: | MRN: | DOB: | Sex: |
|---|---|---|---|

## Release of Information Authorization



**1. Patient Information**

**Name:** | Date of Birth

Address

City | State | ZIP

**2. Health Care Provider of Facility who has the information you want released**

**Marshfield Clinic Health System - All Locations** *(excluding Family Health Center - all locations)* **OR**

**Name/Organization:**

Address

City | State | ZIP

Phone # | Fax #

**3. Where you want the information to be sent**

**Name/Organization:** | Attention

Phone # | Fax #

Address

City | State | ZIP

**4. Why the information is needed**

☐ Continuing Care ☐ Worker's Compensation ☐ School ☐ Personal Use ☐ Legal

☐ Insurance Application ☐ Insurance payment/claim ☐ Form Completion (FMLA/Disability, ect.)

☐ Other _____

**5. What information you want released**

*Complete sections A, B, C,D or E. Do **NOT** 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*

**A. Service Dates:** Between _____ to _____

**Specific Diagnosis or Provider** _____

**B. Send All Routine Records:**

☐ Clinic Notes, History and Physical, Discharge Summary, Consult Report, Emergency Room Report, Operative Report, Lab, Urgent Care Report, Radiology, Procedure notes, Diagnostic Test Results

**C. Select the Specific Records to Release:**

☐ Discharge Summary
☐ History and Physical Exams
☐ Operative/Procedure Reports
☐ Consultation Reports
☐ Billing Records
☐ Diagnostic Test Results
☐ Rehab Reports (PT/OT/Speech)
☐ Medication List
☐ Radiology Reports
☐ FMLA/Disability/Other Form
☐ Pathology Reports
☐ Clinic Notes
☐ Laboratory Reports
☐ Emergency Room/Urgent Care Report
☐ Other _____

**D. Records Requiring Specific Consent:**

***The applicable records must be checked in order to be released***

☐ Psychological Testing
☐ Mental Health Treatment Notes
☐ AODA Treatment Notes
☐ Neuropsychology Notes
☐ HIV/AIDS Results
☐ Genetic Testing Results

**E. Records Requiring Minor Consent:** ***The applicable records must be checked & signed in order to be released***

☐ Outpatient AODA (12+yrs)
☐ Inpatient AODA - Detox Only (12+yrs)
☐ Outpatient mental health care (14+yrs)
☐ Inpatient mental health care (14+yrs)
☐ Neuropsychology notes (14+yrs)
☐ Rape or sexual assault/abuse (12+yrs)
☐ Sexually transmitted disease (17+yrs)
☐ Pregnancy test (17 yrs or younger)
☐ Birth control pills (17 yrs or younger)
☐ Pregnancy-related care or care of newborn (17 yrs or younger)
☐ HIV/AIDS test results (14+yrs)

_____ _____

Patient signature | Date/Time

## Release of Information Authorization (Continued)

| Patient Name: | MRN: | DOB: | Sex: |
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**5. What information you want released (continued)**

*Complete section F if need any of these records*

**F. Radiology Films, Pathology Slide or Photographs** *****All loaned films & slides must be returned within 30 days*****

☐ Radiology Images: _____

☐ Pathology slides: _____

☐ Photographs (define type): _____

☐ Date Mailed: _____ Date Picked Up: _____ By _____

**6. When information is needed by**

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 medicalrecords@marshfieldclinic.org

To check on the status of FMLA/Disability/Other Form: call 1-800-782-8581, Ext. 93676, option 2 or email disability@marshfieldclinic.org

**7. How would you like this information?**

**Release Method/Format Requested:** *Note: Information supplied electronically is in PDF format and is encrypted*

☐ Mailed ☐ Faxed ☐ USB drive ☐ CD/DVD ☐ Email: _____

Other: asf

**8. Expiration**

This authorization is effective for **one year** 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

**Wisconsin - FMLA/Disablity/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

**Michigan Authorizations:**

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

***Fax Form to:*** 715-221-6992
***Email Form to:*** medicalrecords@marshfieldclinic.org

## Release of Information Authorization (Continued)

| 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.

 