Reedsburg
AREA MEDICAL CENTER
Organization Focused

2000 N. Dewey Avenue
Reedsburg, WI 53959
(608) 524-6487 ext 1800
(608) 524-2104 FAX
(608) 524-8305 (Physicians/
Specialty Group Fax)
(608) 524-1046 Med Surg

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name *(First, Middle, Last)*	**Previous/Maiden Name**	**Birth Date (Month DD, YYYY)**	**MRN**
Mailing Address of Patient - Street			
City	**State**	**ZIP Code**	**Phone**

Instructions: if **any** section is incomplete, this form may be invalid and the request cannot be processed.

AUTHORIZES REEDSBURG AREA MEDICAL CENTER TO *RELEASE TO*: (Includes Physician Group and Specialty Group)	**AUTHORIZES REEDSBURG AREA MEDICAL CENTER TO *OBTAIN FROM*: (Includes Physician Group and Specialty Group)**
Name of Health Care Provider/Other	Name of Health Care Provider/Other
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code

☐ Treatment/Continued Care ☐ Personal ☐ Legal Purposes ☐ Disability Determination ☐ Payment of Insurance Claim

☐ Other_____

Information to be Released

Service Dates (approximate)	☐ Copies ☐ Verbal Exchange of Information (No copies) ☐ Review of my Medical Record

☐ History and Physical	☐ EKG's	☐ Laboratory "Reports	☐ Behavioral Health	☐ Consultation
☐ Immunization Records	☐ Pathology Reports	☐ Radiology Reports	☐ Hospital Discharge Summary	
☐ Clinic Notes	☐ Operative Reports	☐ Radiology Images	☐ ER Report	

☐ Other_____

State and Federal Laws require specific authorization prior to disclosing certain information. Please check if you would like any or all of the following information disclosed.

☐ Mental Health ☐ Alcohol/Drug Use ☐ Developmental Disability ☐ HIV Testing

Your Rights With Respect To This Authorization

General Statement of Rights: Federal and state laws protect the confidentiality of my PHI including but not limited to: Mental Health – Sec 51.30, Wis. Stats; & HFS 92, Wis. Admin. Code. Alcohol & Other Drug Abuse – Sec. 51.30 Wis. Stats, HFS 92 Wis. Admin. Code; and 42 CFR Part 2 Final Rule governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may re-disclosure it only in connection with their official duties. Prohibition on re-disclosure. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further re-disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom It pertains or as otherwise permitted by 42 CPF Part 2. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CHF Parts 160 and 164. Right to Receive a Copy of This Authorization: I have a right to receive a copy of this form after I sign it Right to Refuse to Sign This Authorization: I am under no legal obligation to sign this form, however, under certain circumstances permitted under applicable law, refusal to sign may result in denials of services. Right to Withdraw This Authorization: I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the individual/agency authorized to disclose PHI. My withdrawal of consent will not be effective until the individual/agency authorized to disclose PHI receives it, and will not be effective regarding the uses and/or disclosure of my PHI made prior to receipt of my withdrawal statement. Re-disclosure if I authorize release of PHI to an individual or agency not covered by federal or state laws that prohibit re-disclosure, my PHI may not remain confidential. Right to Inspect and/or Copy PHI: I have the right to inspect and receive copies of my PHI as permitted by law. I may be charged a reasonable fee for these copies.

In accordance with the conditions listed on the first page of this form and above, I authorize the use and disclosure of my medical information. By signing this authorization, you understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on you signing this authorization. This authorization may be revoked in writing at any time by submitting a request to Release of Information at the address above. This form must be legible and the first page muse be completed in full in order to be valid. Copies of records may be obtained with reasonable notice and payment of copying costs if applicable.

General Records Only:
This authorization will expire one year from the date of signing unless I indicate an earlier date here: _____

Behavioral Health Records Only:
This authorization is good from date of signature to the date of expiration or unless I indicate an earlier date here: _____

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Spouse/Adult Family Member of Deceased Patient ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Patient Signature *(required)*	**Date Signed** *(required) (Month DD, YYYY)*
Printed Name of Person Signing (if not patient)/Relationship (required)	
Signature of Person Signing (if not patient)/Relationship *(required)*	**Date Signed** *(required) (Month DD, YYYY)*

☐ **Copies given to patient/representative at time of service**

FOR ORGANIZATIONAL USE					
Dt Rec'd	**Dt Disclosed**	**Processed By**	☐ **Mailed**	☐ **Faxed**	☐ **Picked Up By**

REFER TO: 1) Medical Record Review During Hospitalization Protocol—Patient Focused Manual—(RI);
2) Release/Disclosure of PHI Protocol—Org Focused Manual—(IM)
APPROVAL: 04/03 **REVIEWED:** 1/17 2/01/18 7/19 4/21 5/23 **REVISED:** 01/14 02/24
DISTRIBUTION: 1) Organization Focused Manual—Management of Information (IM); **2)** Cross-indexed in HIS Department Manual TOC;
3) ES Manual—(PC) part of the "Sexual Assault Evaluation & Treatment Form"; **4) Stock at:** MCC & Business Office
tlb/Authorization for Disclosure of PHI/