Ascension Wisconsin*
Authorization for Disclosure of Protected Information

Patient Information: _____ _____
Name of Patient/Previous Name | Date of Birth

_____ _____
Street Address | City | State | Zip Code | Phone Number | Email (not all locations)

I authorize the use or disclosure of the above-named patient's health information as described below:

Release Health Information FROM:

_____
Name of Healthcare Facility/Provider

_____
Street Address

_____
City | State | Zip Code

_____

Release Health Information TO:

_____
Name

_____
Street Address

_____
City | State | Zip Code

_____
Fax Number (For Continuing Care Use *Only*)

Information to be Released: (Check all that apply)

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Operative Reports
- ☐ ED Reports
- ☐ Pathology Reports
- ☐ Lab Reports
- ☐ Imaging/Radiology Reports
- ☐ EKG Reports
- ☐ Progress Notes
- ☐ Immunization Records

For the following date(s) of service: _____ to _____

- ☐ Clinical Office Notes
- ☐ Clinical Notes last 2 years
- ☐ Billing
- ☐ Imaging Films/CD
- ☐ Rehab Notes
- ☐ Other _____
- ☐ Pertinent/Summary Information (Discharge Summary, Operatives Notes, Pathology, Lab, EKG, ED, Clinic Visits, Consults)

Purpose of Disclosure:

☐ Continuing Care ☐ Legal ☐ Insurance/Claims ☐ Personal Use ☐ Transfer of Primary Care ☐ Workers Compensation
☐ Other: _____

Date Need By: _____ **Delivery Method:** ☐ Mail ☐ Pick Up ☐ Other: _____

Please Check If You DO NOT Want the Following Information Disclosed:

☐ HIV/AIDS (including test results) ☐ Substance Abuse Records ☐ Behavioral Health Records

Patient Identification Label

Your Rights With Respect to this Authorization:

I understand that:

- "Ascension Wisconsin" refers to all healthcare organizations wholly owned, controlled and/or managed indirectly or directly by Columbia St. Mary's, Inc., Ministry Health Care, Inc. or Wheaton Franciscan Healthcare – Southeast Wisconsin, Inc. or their successor organization. [I have indicated above which facilities have been requested to release my information in accordance with this authorization.]
- I have a right to inspect or receive a copy of any health information used or disclosed.
- I have a right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the Health Information Department. I understand that my revocation will not apply to information that has already been released in response to this authorization.
- If a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected by such laws.

This authorization is voluntary. Ascension Wisconsin will not condition your treatment on this authorization.

This authorization expires 365 days from the date it is signed by the patient unless other noted _____.

_____ _____ _____
Signature of Patient or Authorized Representative Date Time

If you are signing as a parent of the minor patient listed above, you are declaring that your parental rights have not been terminated.

If signed by other than the patient, indicate relationship or authority: Patient is: ☐ Minor ☐ Incompetent ☐ Deceased

I am: ☐ Parent ☐ Legal Guardian ☐ Health Care Agent of Incapacitated Patient ☐ Next of Kin of Deceased ☐ Executor of Estate

If unable to sign, give reason: _____

Signature of Witness: (when applicable) _____ Date: _____ Time: _____

NOTE: "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 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 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Office Use:

Identification/Signature Verified: Date: _____ Time: _____

Date Received: _____ Date Disclosed: _____ Processed By: _____

Ascension Wisconsin complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Patient Identification Label