MINISTRY HEALTH CARE

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

______________________________ Name of Patient/Previous Names

______________________________ Birth Date/Medical Record Number

______________________________ Street Address

______________________________ City, State, Zip, Phone Number

AUTHORIZES DISCLOSURE BY:

______________________________ Name of Health Care Provider/Plan/Other

______________________________ Street Address

______________________________ City, State, Zip Code

DISCLOSURE OF HEALTH INFORMATION TO:

______________________________ Name of Health Care Provider/Plan/Other

______________________________ Street Address

______________________________ City, State, Zip Code

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed:*

- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Consultation
- ❑ Operative Report
- ❑ Pathology Report
- ❑ Radiology Report-Films
- ❑ Laboratory Report
- ❑ Rehab Notes
- ❑ ED 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**

FOR THE FOLLOWING DATES: From: ______________________ To ______________________

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

- ❑ Continuing Care
- ❑ Transfer to New Provider
- ❑ Insurance/Claim Purposes
- ❑ Legal Investigation
- ❑ Disability Determination
- ❑ Personal Use
- ❑ Workers Compensation
- ❑ Vocational Rehab Eval
- ❑ Other: ______________________________

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Receive a Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) 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 Ministry Health Care 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 of withdrawal to the organization's Medical Record/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. ***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. ****WI Statutes 51.30 and 252.15** requires patient authorization to disclose health information for payment purposes. **Copy or Facsimile (FAX) Valid as an Original.**

EXPIRATION DATE: This authorization is good until the following date(s) ______________ or for one 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.

SIGNATURE PATIENT/LEGAL REP.: ______________________________ **DATE:** ______________

(If signed by other than patient, state relationship and authority to do so.)

FOR ORGANIZATIONAL USE					
Dt Received:	Dt Disclosed:	Processed By:	❑ Mailed	❑ Faxed	❑ Picked Up By: