PATIENT INFORMATION:

Appointment Date: _____

_____
Name of Patient/Previous Names

_____
Birth Date/Medical Record Number

_____
Street Address

_____
City, State, Zip, Phone Number

AUTHORIZES DISCLOSURE BY:
☐ Affinity Health System
Or By:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

DISCLOSURE OF HEALTH INFORMATION TO:
☐ Affinity Health System
Or 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 ☐ Clinical Office Notes ☐ Last 2 yrs Clinical Office Records ☐ Immunizations
☐ Billing ☐ 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 ☐ Personal Use ☐ Insurance/Claim Purposes ☐ Legal Investigation
☐ Disability Determination ☐ Workers Compensation ☐ Verbal Use Only ☐ Seeking Second Opinion
☐ Moving out of the Area ☐ Application for Insurance ☐ Other: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Receive a Copy of the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or receive a copy (at a reasonable fee) of 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 Affinity Health System 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 Affinity Health System. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. 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.

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.)

PATIENT HAND CARRIED RECORDS: Signature: _____ Date: _____

Affinity HEALTH SYSTEM

❑ Affinity Medical Group ❑ Network Health Plan
❑ Affinity Occupational Health ❑ St. Elizabeth Hospital
❑ Calumet Medical Center ❑ Surgery Center
❑ Mercy Medical Center ❑ _____

Patient Identification

AUTHORIZATION for DISCLOSURE of PROTECTED HEALTH INFORMATION

3/09 #0042864