❒ **Columbia St. Mary's Hospital Milwaukee** ..... Telephone: 414-585-1112
2323 N. Lake Dr., P.O. Box 503, Milwaukee, WI 53201-0503 ..... Fax: 414-585-1113

❒ **Columbia St. Mary's Hospital Ozaukee** ..... Telephone: 262-243-7480
13111 N. Port Washington Rd., Mequon, WI 53097 ..... Fax: 262-243-7329

❒ **Columbia St. Mary's Sacred Heart Rehabilitation Institute** ..... Telephone: 414-585-6718
2323 N. Lake Dr., Milwaukee, WI 53211 ..... Fax: 414-585-6712

❒ **Other**

AUTHORIZATION FOR USE / DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

MR #:

ID Verified:

_____ / _____ _____
(Patient Name) (Previous Name) (DOB)

Address, City, State, Zip _____

❒ I authorize the above noted facility to release information from my medical records to the person/institution named below:
❒ I authorize the following person/institution to release information from my medical records to the above noted facility:

Name _____ Phone # _____ Fax # _____

Address, City, State, Zip _____

❒ Mail ❒ Pick-up Date / Time _____ / _____ ❒ Other _____ Patient's Phone Number _____

INFORMATION TO BE RELEASED: (Check all that apply)

❒ Discharge Summary
❒ History & Physical
❒ Consultation Reports
❒ Operative Reports
❒ ER Reports
❒ Lab Reports
❒ EKG
❒ AIDS / HIV Test and / or Treatment
❒ Team Conference Reports
❒ Therapy Evaluations

Dates of Service: _____

❒ X-Ray Reports
❒ X-Ray Films – # sent _____
Original Films must be returned within 30 days

❒ Other (specify) _____

PURPOSE FOR DISCLOSURE:

❒ Further medical care
❒ Application for insurance
❒ Disability determination
❒ Legal investigation
❒ Vocational rehab eval
❒ Other _____
❒ Payment of claims / benefits
❒ Personal

I authorize release of my medical record/films in accordance with the specifications listed above. I understand that the above noted facility will not condition treatment or payment on the signing of this authorization except where the provision of healthcare is solely for the purpose of creating health care information for disclosure to a third party. I have the right to revoke this authorization (by written notification only to the Operations Manager in the Medical Record Department) except to the extent that information was released, as authorized, prior to notice of the revocation. I understand that I do not have the right to revoke this Authorization if it was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim under the policy. This consent will remain in effect until the following date or event _____ and in all cases expires in one (1) year.

The information disclosed as the result of this authorization might be redisclosed by the person receiving it and may no longer be protected by privacy protections under Federal Law.

CHECK ONE OF THE FOLLOWING:

❒ I am the patient.
❒ I am the parent of the above named minor child and I represent that I have not been denied access to my child by a court of law and / or denied periods of physical placement with my child.
❒ I am the legal guardian of the above named patient (proof of guardianship required).
❒ I am the next-of-kin of the above names deceased patient (proof of death required).
❒ I am the executor / personal representative of the estate of the above named deceased patient (proof required).
❒ I am the above named patient's Durable Power of Attorney for Healthcare Agent (proof and activation of DPOA required).

Date: _____ Time _____ Signature _____

Date: _____ Time _____ Witness _____

THE HOSPITAL RESERVES THE RIGHT TO CHARGE FOR COPYING MEDICAL RECORDS

BARCODE

IF THIS IS A 2-PLY FORM: BOTH SUFFICE AS ORIGINAL FAX IS AS GOOD AS ORIGINAL

Copy will be provided to patient when authorization is requested by CSM or upon request by patient.