PROHEALTH CARE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Medical Record Number ____________
Home Phone: ____________
Date of Birth: ____________

Patient Name: ____________ (Last) ____________ (First) ____________ (Middle) ____________ (Maiden/Other)

Address ____________ City ____________ State ______ Zip ____________

I authorize and give permission for:
- ☐ PHC, Oconomowoc Memorial Hospital (262) 569-0258
- ☐ PHC, Waukesha Memorial Hospital (262) 928-2580
- ☐ PHCMA - Name Clinic ____________
- ☐ ProHealth Solutions Participating Practice/Office ____________
- ☐ Organization/Individual ____________

____

____
Other Health Care Facility, include address

To release information to:
- ☐ PHC, Oconomowoc Memorial Hospital
- ☐ PHC, Waukesha Memorial Hospital
- ☐ PHCMA - Name Clinic ____________
- ☐ ProHealth Solutions Participating Practice/Office ____________
- ☐ Organization/Individual ____________

____
Street Address

____
City State Zip

Fax Number ____________ (Physician Office Only) Other ____________

I understand that authorizing the release of this protected health information (PHI) is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, enrollment, or eligibility for benefits. I understand that any release of PHI carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

I fully understand that my PHI in connection with the services date(s) stated below may include reference to treatment of alcohol and drug abuse, psychiatric care, developmental disabilities, HIV test results/acquired immune deficiency syndrome, intoxication tests and/or fetal monitor tracings.
Unless otherwise revoked, this authorization will expire on the following date or event: ____________
If I fail to specify an expiration date or event, this authorization will expire six months from the date signed.

PHI to be released:
Date(s) of service from ____________ to ____________
- ☐ Ambulance Record
- ☐ Cardiac Studies
- ☐ Consultation
- ☐ Disability Records
- ☐ Discharge Summary
- ☐ Electrocardiograms (EKG)
- ☐ Emergency Room Report
- ☐ History & Physical
- ☐ Immunization Records
- ☐ Laboratory Reports
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Progress Notes
- ☐ Radiology Films
- ☐ Radiology Reports
- ☐ Rehab/Therapy Notes
- ☐ Specify other records:
  - 8 x 10 ____ film
  - 10 x 12 ____ film
  - 14 x 17 ____ film
  - Image CD ______
- ☐ Other ____________

The reason of this release is: (Check one/more of the following)
- ☐ Continued Medical Care
- ☐ Disability Determination
- ☐ Insurance Application
- ☐ Insurance Filing
- ☐ Legal Investigation
- ☐ Payment of Claim/Benefits
- ☐ Personal Use
- ☐ Workman's Comp
- ☐ Other, please specify ____________

I understand that a photocopy shall be considered as valid as the original. I may inspect and arrange for photocopies of the information that is to be disclosed with the Health Information Management (HIM) department. I understand that I have a right to cancel this authorization at any time by providing written notice to HIM department. I understand that the cancellation will not apply to information that has already been released in response to this authorization. I understand that cancellation will not apply to my insurance company as needed to contest a claim under my policy.

In compliance with Wisconsin Statutes which require special permission to release the below PHI, please release records pertaining to:
- ☐ Alcohol/Drug Treatment Records
- ☐ Drug Abuse or test results
- ☐ Developmental Disabilities
- ☐ HIV test results, AIDS or AIDS-Related disease
- ☐ Mental Health Records
- ☐ SANE Documents
- ☐ SANE Photos
- ☐ Sexually Transmitted Disease
- ☐ Other ____________

Re-Release: I agree that re-release of PHI from: ☐ PHC Oconomowoc Memorial Hospital ☐ PHC Waukesha Memorial Hospital ☐ PHCMA Clinic (name) ____________ ☐ Other: ____________
can be made to: ☐ PHC Oconomowoc Memorial Hospital ☐ PHC Waukesha Memorial Hospital
☐ PHCMA Clinic (name) ____________
Other: ____________
Name Address City State Zip

Check one: ☐ verbal release ☐ paper release ☐ electronic/digital release/CD. Clearly provide email address ____________
Release by: ___ US Mail ___ Pick-Up: Location ____________

Signature of Patient: ____________ Date: ________ Time: ________
Signature of Guardian or
or Legal Representative: ____________ (State relationship to patient) Date: ________ Time: ________
Signature of Witness: ____________ Date: ________ Time: ________
To be signed only if patient cannot sign.
Information Released By: ____________ Date: ________ Time: ________

Signature of person releasing information: ____________ Unit ________ Ext. ________

This form meets requirements as defined in WI Statutes 146.81-83, 51.30, 252.15, and Federal Regulations 42CFR2 and 45CFR164.508, 164.508(a), 45CFR (Part 5b)

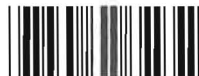
Provide a copy of this completed form to the signing individual.

OFFICE USE ONLY:
Requested by: ____________ Info released by: ____________ Date picked up/released: ____________

ReRelease authorized by patient contact. Initials: ________ Date ________ Time ________

PATIENT LABEL

REC-48
(05/12)


507 AUTHORIZATION

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