Release of Protected Health Information Authorization

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| --- |
| Name |
| ID Number | DOB | Age | Gender |

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| --- | --- | --- | --- |
| **A** |  | Previous last name (if any) | Daytime phone number |
| **Patient** |
| Address |
| City | State | ZIP |
| **B** |  | Address City State ZIP Phone Fax  |
| **Who has the information that is to be released** |
| **C** |  | Name | Phone number |
| **To whom the information should be released** |
| Attention | Fax |
| Address |
| City | State | ZIP |
|  **D** **Medical records or other records****to be disclosed** Check (✓) box(es) of the records to be released per this request (if minoris signing this authorization, see section titled “Special medical record release by minor”) | Medical records: Consults Correspondence X-ray reports *(See E)**Section*Medical history and notes Dental Surgical reports HIV/AIDS test results Laboratory/Pathology reports Prescriptions Hospital records Forms/Opinion reports Billing/Financial records Immunizations School records Third-party records By specific doctor, for a specific diagnosis or a specific date range Other, specify  |
| Mental health/alcohol & other drug abuse/neuropsychology records:Specify facility:Mental health and/or Alcohol & other drug abuse and/or NeuropsychologyBy specific doctor, for a specific diagnosis or a specific date range Other, specify  |
|  **E** **Radiology films, pathology slides, or photographs to be disclosed** | Check (✓) boxes below for the films, slides or photographs to be released per this request:Original x-ray of Mailed date (m/d/y) / / l Photographs l (return loaned films/slides within 30 days) (define type ) Pick up date (m/d/y) / / Pathology slides of By  |
|  **F** **Method of release** | Email (use of encryption required) Email address Paper Other, specify *Note: Information supplied electronically is in PDF format and is encrypted.* |

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| --- | --- | --- | --- | --- |
| Patient name | MHN | DOB | Age | Gender |
|  **G**  | I am a minor and I have received medical care that requires or allows me to consent to the release of medical records of this care to my parents or any one else.Check (✓) boxes of medical records to be disclosed:Outpatient alcohol or other drug dependency care (12 years or older)*(parent may also be required to sign below)*Inpatient alcohol or other drug dependency care – detoxification only (12 years or older)*(parent may also be required to sign below)*Rape or sexual assault/abuse (12 years or older) *(parent may also be required to sign below)*Outpatient mental health care (14 years or older) Inpatient mental health care (14 years or older)Neuropsychology notes (14 years or older) *(parent may also be required to sign below)*HIV/AIDS test results (14 years or older)Sexually transmitted disease (17 years or younger)Pregnancy test (17 years or younger) *(parent may also be required to sign below)*Birth control pills or devices (17 years or younger) *(parent may also be required to sign below)*Pregnancy-related care or care of newborn (17 years or younger)Physician at Marshfield Clinic Health System (e.g. my spouse, parent, child) can access my electronic medical record (EMR) including but not limited to information above *(parent may also be required to sign below)*Patient signature Date (m/d/y) / /  |
| **Special medical record release by minor** |
|  **H**  | Check (✓) box below to indicate the reason for the release per this request:Continuing health care needs Preemployment or medical evaluationDisability Billing, collection or payment of claimsTransfer of care Post-employment testing or medicalCare coordination or case management Employment determination (non-work-related Second opinion/referral illness or injury)Personal LitigationsFinancial assistance Other, specify  |
| **Reason for the release** |
|  **I**  | This authorization will remain in effect:From the date this authorization is signed until the day of , 20 Until you cancel this authorization in writing.Until the following event occurs, specify event Other, specify  |
| **Expiration** Check (✓) box to indicate the expiration per this request |

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| Patient name | MHN | DOB | Age | Gender |

By signing this, you specifically authorize the use and disclosure of the information you selected above. You acknowledge that you have reviewed and understand this authorization form.

J

 / /

Patient signature (Patient’s legal representative) (Relationship to patient) Signature date (m/d/y) Phone number

