Release of Protected Health Information Authorization

Name			
ID Number	DOB	Age	Gender

A Patient

Previous last name (if any)		Daytime phone number	
Address			
City		State	ZIP

B Who has the information that is to be released

Address _____

City _____ State _____ ZIP _____

Phone _____

Fax _____

C To whom the information should be released

Name		Phone number	
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 minor is signing this authorization, see section titled "Special medical record release by minor")

Medical records:

☐ Consults ☐ Correspondence ☐ X-ray reports *(See Section E)*

☐ 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 ☐ Neuropsychology

☐ By 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) _____ /_____ /_____

☐ Photographs (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.

Release of Information Authorization (Continued)

Patient name	MHN	DOB	Age	Gender

G

Special medical record release by minor

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) _____ /_____ /_____

H

Reason for the release

Check (✓) box below to indicate the reason for the release per this request:

- ☐ Continuing health care needs
- ☐ Disability
- ☐ Transfer of care
- ☐ Care coordination or case management
- ☐ Second opinion/referral
- ☐ Personal
- ☐ Financial assistance
- ☐ Preemployment or medical evaluation
- ☐ Billing, collection or payment of claims
- ☐ Post-employment testing or medical
- ☐ Employment determination (non-work-related illness or injury)
- ☐ Litigations
- ☐ Other, specify _____

I

Expiration
Check (✓) box to indicate the expiration per this request

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 _____

Release of Information Authorization (Continued)

Patient name	MHN	DOB	Age	Gender

J

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.

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