SSMHealth

o SCAN ONLY-No additional information needed

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in full. See reverse side for important information.)

1.

Name of Patient ____________________

Street Address ____________________

City, State, Zip ____________________

Date of Birth ____________________

Phone # ____________________

I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization by providing written notice to SSM Health Health Information. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. AUTHORIZE:

____
(Name of Physician/Health Care Facility/Other)

____
(Street Address)

____
(City, State, Zip)

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:
(If release is to self, state self)

____
(Name of Physician/Health Care Facility/Other)

____
(Street Address)

____
(City, State, Zip)

____
(Fax)

4. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

o Continuing Care o Transferring Care (Customary to release last 2 years of information. Release may occur electronically)

o Personal Use o Insurance Eligibility/Benefits o Disability Determination o Legal Investigation o Needed by/Appt Date ______/______/_______ (MM DD YYYY)

o Other (specify):____________________

5. HEALTH INFORMATION TO BE RELEASED:

Office Visits: o Primary Care o Specialty (specify) ____________________ o Procedures

o Immunization Records o Lab Reports o X-ray Reports o X-ray Films (specify)______________ o Billing Records (specify) ______________

o Specific information related to: ____________________

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: ______/______/_______ (MM DD YYYY) To: ______/______/_______ (MM DD YYYY)

5a. Federal and state laws require special permission to release certain information. Please check if these records should be released:

o Mental Health o Alcohol and/or Drug Abuse o HIV/AIDS Test Results o Developmental Disabilities

6. FORMAT FOR RECORDS: o MyChart o DVD/CD o Paper o Verbal Disclosure

o Email to: ____________________

7. EXPIRATION

This authorization will expire on ______/______/_______ (MM DD YYYY). If I do not indicate a date, this will expire one (1) year from the date of my signature below.

A photocopy of this authorization is as valid as the original.

8. SIGNATURE

I understand that this authorization is voluntary. I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: ____________________ Date: ______________

If this Authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name: ____________________

Relationship to Patient: ____________________

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

ADDITIONAL INFORMATION REGARDING RELEASE OF HEALTH INFORMATION

SSM Health recognizes the patient's right to confidentiality of their health information under federal privacy regulations and Wisconsin law. The patient should be aware of the following information when requesting or releasing health information.

- **Record Definition:** The record(s) defined for release include record(s) generated at all SSM Health locations.
- **Right to Refuse to Sign This Authorization:** A patient may refuse to sign this Authorization and this refusal will not affect the patient's ability to obtain treatment or payment of claims.
- **Right to Inspect or Copy the Health Information to Be Used or Disclosed:** A patient has the right to inspect or copy the health information they have authorized to be used or disclosed by signing this Authorization form. A patient may arrange to inspect their health information by contacting the office listed below.
- **Right to Receive Copy of This Authorization:** A patient has the right to receive a copy of the signed Authorization form.
- **Right to Revoke This Authorization:** A patient has the right to revoke this Authorization at any time by giving written notice of revocation to the Privacy Officer listed below. Revocation of this Authorization will not affect any action taken in reliance of this authorization before receipt of the written notice of revocation.
- **Multiple Releases of Information:** A patient may request multiple releases of the information stated on the Authorization form as long as the authorization is not expired.
- **Who May Sign This Authorization:**
  1. Generally, all patients 18 years of age and older must sign for release of their own health information unless the following conditions apply:
     a. The patient is incompetent
     b. The patient is disabled and cannot sign the form
     c. The patient is deceased. (A surviving spouse or personal representative of the estate may sign. If there is no surviving spouse or personal representative, then an adult member of the immediate family may sign.)
  2. All persons signing for release of health information on behalf of the patient must state their relationship to the patient and provide proof of legal authority of their capacity to act for the patient.
  3. Minors: Patients less than 18 years of age must sign for release of their health information in the following cases:
     a. Alcohol or other drug abuse treatment: age 12 or older
     b. Mental health treatment: age 14 or older may consent to release of records without parental consent (Parents also retain the right to access this information.)
     c. HIV test results: age 14 or older
     d. Emancipated minors who are married or in the military
- **Fees for Records:** SSM Health may charge a reasonable fee for viewing, copying, postage and preparation of records to fulfill this request. All fees are based on the applicable laws governing release of health information.
- **Contact Office:**

  Requests for **release of health information** can be directed to the Health Information Department.

Dean Medical Group
St. Mary's Hospital-Madison
St. Mary's Hospital-Janesville
St. Clare Hospital-Baraboo
Monroe Hospital and Clinic
Attn: Release
PO Box 259840
Madison, WI 53725-9840
Phone: 608-294-6244
Fax: 608-294-6294
Email: healthinformation@ssmhealth.com

St. Agnes Hospital
Ripon Community Hospital
Waupun Memorial Hospital
Fond du Lac Regional Clinic
Attn: Release
420 East Division
Fond du Lac, WI 54935
Fax: 920-926-4861
Email: GFDLHIM@ssmhealth.com