LABEL

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION AGNESIAN HEALTHCARE

Consultants Laboratory
430 E. Division Street
Fond du Lac, WI 54935

Fond du Lac Regional Clinic
420 E. Division Street
Fond du Lac, WI 54935

Ripon Medical Center
845 Parkside Street
Ripon, WI 54971

St. Agnes Hospital
430 E. Division Street
Fond du Lac, WI 54935

St. Francis Home
33 Everett Street
Fond du Lac, WI 54935

Waupun Memorial Hospital
620 W. Brown Street
Waupun, WI 53963

Agnesian HealthCare Enterprises
430 E. Division Street
Fond du Lac, WI 54935

1. Regarding Patient/Resident

_____
Name - last, first, middle

_____
Maiden name or other name

_____
Street Address / P.O. Box

_____
City, State, Zip Code

_____
Telephone Number

_____
Birthdate

2. Health information: ❑ released to ❑ exchanged with

❑ mail ❑ pick-up - date: _____

❑ email to: _____ ***(MEDICAL IMAGING FILES ONLY)***

❑ Password (hospital use): _____

_____
Name of individual(s) / Organization

_____
Name of individual(s) / Organization

_____
Street Address / P.O. Box OR Additional Name

_____
City, State, Zip Code OR Additional Name

_____ _____
Telephone number Fax number

FOR PICK-UPS, PLEASE LIST WHO WILL PICK-UP RECORDS:

_____
Name

3. PROVIDER USE – For Referral Purpose complete the following:

Diagnosis: _____

Provider: _____ Department: _____

❑ Froedtert ❑ Children's Hospital of WI ❑ UW-Madison ❑ Other: _____

Check to send last results of:

- ❑ Provider Notes _____
- ❑ Labs _____
- ❑ Medical Imaging Report ❑ CD ❑ _____
- ❑ Pathology _____
- ❑ Cardiology Studies (EKG/Echo/Stress Test) _____
- ❑ Specify other notes: _____

4. I authorize the following facility to disclose the health information identified in Section 5: ❑ St. Agnes Hospital ❑ St. Francis Home

❑ Waupun Memorial Hospital ❑ Consultants Laboratory ❑ Ripon Medical Center ❑ Agnesian HealthCare Enterprises

❑ Fond du Lac Regional Clinic, site location: _____

❑ Other: _____

_____ _____
Street City, State, Zip Code

(CONTINUED ON BACK)

Fax form to:
❑ ROI: (920) 926-8910
❑ Medical Imaging (Films): (920) 926-4868

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5. Specific type of health information to be disclosed:

❑ All health records (last 2 years) ❑ Progress Notes ❑ Discharge Summary ❑ Medications
❑ History & Physical ❑ Therapy Notes ❑ Outpatient Report ❑ Condition Updates
❑ Lab Reports ❑ Vision Records ❑ Immunization Record
❑ Medical Imaging: ❑ Other (specify): _____
❑ CD ❑ Reports ❑ Echo _____

Health information protected by federal confidentiality rules (42CRF part 2)

❑ BH Diagnoses ❑ BH Mental status exam ❑ BH Attendance ❑ Psychological testing
❑ Drug/alcohol history ❑ BH Physical exam ❑ Psychiatric history ❑ BH Medication management
❑ BH Treatment summary or plan ❑ BH Initial intake/assessment ❑ BH Discharge/summary transfer ❑ Psychotherapy notes
❑ AODA ❑ Hepatitis B ❑ AIDS (acquited immune deficiency syndrome)
❑ HIV infection ❑ TB (tuberculosis) ❑ STD (sexually transmitted disease(s) ❑ Sickle cell anemia
❑ Other: _____

6. Date(s) of health information to be disclosed and/or chronic condition: _____

_____ _____

_____ _____

7. Disclosure may be in the form of: ❑ Photocopies ❑ Fax ❑ Verbal communication ❑ Inspection ❑ Written correspondence

8. Purpose or need for disclosure: ❑ Continuity of care ❑ Personal use ❑ Second opinion
❑ Payment of insurance claim ❑ Application for insurance ❑ Legal investigation ❑ Disability determination
❑ Other _____

9. **I understand that this authorization** may be revoked by me at anytime (except that the facility has already acted in reliance on it) by written notice to the appropriate Health Information Management Department. I have the right to inspect and receive a copy of the material to be disclosed and receive a copy of the informed consent. This consent will remain in effect until the above request is processed or unless otherwise specified. When health information is disclosed to anyone except a covered facility it would no longer be protected under HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations. Signing this authorization is voluntary and I may refuse to sign. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits.

Prohibition of Disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and Wisconsin Statute 51.30). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand I may inspect and receive a copy of the disclosed information.

10. I understand that a photocopy of this consent is as valid as the original. This consent is valid for a period of one (1) year.

11. Signature of Patient: _____ **Date & Time Signed:**_____

12. If signed by person other than the patient, complete the following:
Patient is: ❑ minor ❑ incompetent ❑ disabled ❑ deceased
Legal authority: ❑ parent of minor* ❑ legal guardian ❑ next of kin of deceased ❑ Power of Attorney for HealthCare (attach POA document)
***For minors:** Are you the parent of the child? ❑ yes ❑ no If so, have you ever been denied custody of this child? ❑ yes ❑ no

Signature of person legally authorized to sign:_____**Date:** _____**Time:**_____

OFFICE USE ONLY **Date of request:** _____
Records sent: _____ Copies by:_____
Initials: _____ Date: _____Time: _____
Released to: _____
Patient's charge for records: _____
This information was: ❑ Hand carried by patient
❑ Hand carried by ❑ Mailed first class
❑ Express mailed ❑ Fax
❑ Other:_____

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