LABEL

Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
Consultants Laboratory
Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

1.

_____
Name of Patient/Resident

_____
Street Address

_____
City, State, Zip code

_____ _____
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. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. 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
- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

  _____
- ❑ Other: _____

  Address: _____

  _____

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 code)

_____
(Fax number)

For Pick-Ups, please list who will pick-up records:
Name:_____

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

❑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:_____/_____/_____
MM DD YYYY

❑ Worker's Compensation Research ❑ Other (specify):_____

(CONTINUED ON BACK)

ROI

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

❑ Specific information related to: _____

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: _____/_____/_____ to: _____/_____/_____
MM DD YYYY MM DD YYYY

❑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. Disclosure may be in the form of: ❑ Photocopies ❑ Fax ❑ Inspection ❑ CD/DVD ❑ Verbal Disclosure ❑ email: _____

7. EXPIRATION

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

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

8. SIGNATURE

I understand that this authorization is voluntary. I understand that there may be a charge for copies. 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 (please print): _____ Patient is: ❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

9. Prohibition of Disclosure for Substance Use Disorder: 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. You are entitled to a copy of this authorization after you sign it.

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 ❑ Mailed first class
❑ Hand carried by ❑ Express mailed ❑ Fax
❑ Other: _____

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

ROI

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Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

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Name of Patient/Resident

_____
Street Address

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City, State, Zip code

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Date of Birth Phone #

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- ❑ Ripon Medical Center
- ❑ Agnesian HealthCare Enterprises
- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

  _____
- ❑ Other: _____

  Address: _____

  _____

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:

(If Release is to Self, State Self)

Post my child's photo on agnesian.com in the web nursery
(Name of Physician/Health Care Facility/Other)

_____
(Street Address)

_____
(City, State, Zip code)

_____
(Fax number)

For Pick-Ups, please list who will pick-up records:

Name:_____

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

❑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:_____/_____/_____
MM DD YYYY

❑ Worker's Compensation Research ☑ Other (specify):Post photo on website, post on agnesian.com in the Web Nursery

(CONTINUED ON BACK)

ROI

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: Photo of my child

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: _____/_____/_____ to: _____/_____/_____
MM DD YYYY MM DD YYYY

❑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

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Signature: _____ Date: _____

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Representative's Name (please print): _____ Patient is: ❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

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

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

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Villa Loretto & Villa Rosa
Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

1.

_____
Name of Patient/Resident

_____
Street Address

_____
City, State, Zip code

_____ _____
Date of Birth Phone #

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- ❑ Consultants Laboratory
- ❑ Ripon Medical Center
- ❑ Agnesian HealthCare Enterprises
- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

  _____
- ❑ Other: _____

  Address: _____

  _____

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:

(If Release is to Self, State Self)

Post my child's photo on agnesian.com in the web nursery
(Name of Physician/Health Care Facility/Other)

Post my child's photo on bulletin board on 4th floor
(Street Address)

_____
(City, State, Zip code)

_____
(Fax number)

For Pick-Ups, please list who will pick-up records:

Name:_____

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

❑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:_____/_____/_____
MM DD YYYY

❑ Worker's Compensation Research ☑ Other (specify):_Photo of my child, Post my child's photo on agnesian.com in the web nursery,
Post my child's photo on bulletin board on 4th floor

(CONTINUED ON BACK)

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: Photo of my child

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: _____/_____/_____ to: _____/_____/_____
MM DD YYYY MM DD YYYY

❑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. Disclosure may be in the form of: ☑ Photocopies ❑ Fax ❑ Inspection ❑ CD/DVD ❑ Verbal Disclosure ❑ email: _____

7. EXPIRATION

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

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

8. SIGNATURE

I understand that this authorization is voluntary. I understand that there may be a charge for copies. 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 (please print): _____ Patient is: ☑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ☑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

9. Prohibition of Disclosure for Substance Use Disorder: 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. You are entitled to a copy of this authorization after you sign it.

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 ❑ Mailed first class
❑ Hand carried by ❑ Express mailed ❑ Fax
❑ Other: _____

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

ROI

LABEL

Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
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Fond du Lac Regional Clinic
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St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

1.

_____
Name of Patient/Resident

_____
Street Address

_____
City, State, Zip code

_____ _____
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. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. 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
- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

  _____
- ❑ Other: _____

  Address: _____

  _____

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 code)

_____
(Fax number)

For Pick-Ups, please list who will pick-up records:
Name:_____

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

❑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:_____/_____/_____
MM DD YYYY

❑ Worker's Compensation Research ☑ Other (specify):communication with those identified

(CONTINUED ON BACK)

ROI

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: health information related to this encounter

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: _____/_____/_____ to: _____/_____/_____
MM DD YYYY MM DD YYYY

❑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. Disclosure may be in the form of: ❑ Photocopies ❑ Fax ❑ Inspection ❑ CD/DVD ☑ Verbal Disclosure ❑ email: _____

7. EXPIRATION

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

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

8. SIGNATURE

I understand that this authorization is voluntary. I understand that there may be a charge for copies. 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 (please print): _____ Patient is: ❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

9. Prohibition of Disclosure for Substance Use Disorder: 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. You are entitled to a copy of this authorization after you sign it.

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 ❑ Mailed first class
❑ Hand carried by ❑ Express mailed ❑ Fax
❑ Other: _____

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

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Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
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St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

1.

_____
Name of Patient/Resident

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Street Address

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City, State, Zip code

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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. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

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- ❑ Fond du Lac Regional Clinic, site location:

  _____
- ❑ Other: _____

  Address: _____

  _____

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:
(If Release is to Self, State Self)

_____
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For Pick-Ups, please list who will pick-up records:
Name:_____

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

☑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:_____/_____/_____
MM DD YYYY

❑ Worker's Compensation Research ❑ Other (specify):_____

(CONTINUED ON BACK)

ROI

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: Condition updates

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: _____/_____/_____ to: _____/_____/_____
MM DD YYYY MM DD YYYY

❑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

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

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

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Name of Patient/Resident

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Street Address

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City, State, Zip code

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Date of Birth Phone #

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- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

  _____
- ❑ Other: _____

  Address: _____

  _____

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:
(If Release is to Self, State Self)

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(Name of Physician/Health Care Facility/Other)

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(Street Address)

_____
(City, State, Zip code)

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(Fax number)

For Pick-Ups, please list who will pick-up records:
Name:_____

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

❑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:_____/_____/_____
MM DD YYYY

❑ Worker's Compensation Research ☑ Other (specify):communication with those identified

(CONTINUED ON BACK)

ROI

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: health information related to this encounter

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: _____/_____/_____ to: _____/_____/_____
MM DD YYYY MM DD YYYY

❑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. Disclosure may be in the form of: ❑ Photocopies ❑ Fax ❑ Inspection ❑ CD/DVD ☑ Verbal Disclosure ❑ email: _____

7. EXPIRATION

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

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

8. SIGNATURE

I understand that this authorization is voluntary. I understand that there may be a charge for copies. 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 (please print): _____ Patient is: ❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

9. Prohibition of Disclosure for Substance Use Disorder: 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. You are entitled to a copy of this authorization after you sign it.

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 ❑ Mailed first class
❑ Hand carried by ❑ Express mailed ❑ Fax
❑ Other: _____

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

ROI

LABEL

Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
Consultants Laboratory
Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

1.

Name of Patient/Resident

Street Address

City, State, Zip code

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. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. 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
- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

☑ Other: Doll and Associates Phone: (920) 907-8201

Address: 40 Camelot Drive Fax: (920) 907-8209

Fond du Lac, WI 54935

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 code)

(Fax number)

For Pick-Ups, please list who will pick-up records:

Name:

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

☑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:____/____/____
MM DD YYYY

❑ Worker's Compensation Research ❑ Other (specify):

(CONTINUED ON BACK)

ROI

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: BH diagnoses, treatment plan/summary, BH assessments, psychotherapy notes, discharge summary, transfer summary, psychological testing, attendance history, mental status exam

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: _____/_____/_____ to: _____/_____/_____
MM DD YYYY MM DD YYYY

☑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. Disclosure may be in the form of: ☑ Photocopies ☑ Fax ❑ Inspection ❑ CD/DVD ☑ Verbal Disclosure ❑ email: _____

7. EXPIRATION

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

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

8. SIGNATURE

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Signature: _____ Date: _____

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

Representative's Name (please print): _____ Patient is: ❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

9. Prohibition of Disclosure for Substance Use Disorder: 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. You are entitled to a copy of this authorization after you sign it.

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 ❑ Mailed first class
❑ Hand carried by ❑ Express mailed ❑ Fax
❑ Other: _____

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

ROI

LABEL

Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
Consultants Laboratory
Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

1.

_____
Name of Patient/Resident

_____
Street Address

_____
City, State, Zip code

_____ _____
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. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. 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
- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

  _____
- ❑ Other: _____

  Address: _____

  _____

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:

(If Release is to Self, State Self)

Doll and Associates
_____
(Name of Physician/Health Care Facility/Other)

40 Camelot Drive
_____
(Street Address)

Fond du Lac, WI 54935
_____
(City, State, Zip code)

(920) 907-8209
_____
(Fax number)

For Pick-Ups, please list who will pick-up records:

Name:_____

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

☑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:_____/_____/_____
MM DD YYYY

❑ Worker's Compensation Research ❑ Other (specify):_____

(CONTINUED ON BACK)

ROI

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: BH diagnoses, treatment plan/summary, BH assessments, psychotherapy notes, discharge summary, transfer summary, psychological testing, attendance history, mental status exam

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: _____/_____/_____ to: _____/_____/_____
MM DD YYYY MM DD YYYY

☑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. Disclosure may be in the form of: ☑ Photocopies ☑ Fax ❑ Inspection ❑ CD/DVD ☑ Verbal Disclosure ❑ email: _____

7. EXPIRATION

This authorization will expire on _____/_____/_____. If I do not indicate a date, this will expire one (1) year from the date of my signature below.
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A photocopy of this authorization is as valid as the original.

8. SIGNATURE

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Signature: _____ Date: _____

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Representative's Name (please print): _____ Patient is: ❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

9. Prohibition of Disclosure for Substance Use Disorder: 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. You are entitled to a copy of this authorization after you sign it.

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 ❑ Mailed first class
❑ Hand carried by ❑ Express mailed ❑ Fax
❑ Other: _____

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

ROI

LABEL

Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
Consultants Laboratory
Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

1.

_____
Name of Patient/Resident

_____
Street Address

_____
City, State, Zip code

_____ _____
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. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. 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
- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

  _____
- ❑ Other: _____

  Address: _____

  _____

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 code)

_____
(Fax number)

For Pick-Ups, please list who will pick-up records:
Name:_____

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

❑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:_____/_____/_____
MM DD YYYY

❑ Worker's Compensation Research ❑ Other (specify):_____

(CONTINUED ON BACK)

ROI

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: **Continuing Care Plan Discharge Packet (History & Physical, Continuing Care Plan, Patient Discharge Instructions and Discharge Summary)**

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: _____/_____/_____ to: _____/_____/_____
MM DD YYYY MM DD YYYY

☑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. Disclosure may be in the form of: ❑ Photocopies ❑ Fax ❑ Inspection ❑ CD/DVD ❑ Verbal Disclosure ❑ email: _____

7. EXPIRATION

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

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

8. SIGNATURE

I understand that this authorization is voluntary. I understand that there may be a charge for copies. 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 (please print): _____ Patient is: ❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

9. Prohibition of Disclosure for Substance Use Disorder: 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. You are entitled to a copy of this authorization after you sign it.

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 ❑ Mailed first class
❑ Hand carried by ❑ Express mailed ❑ Fax
❑ Other: _____

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

ROI

LABEL

Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
Consultants Laboratory
Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

1.

Name of Patient/Resident

Street Address

City, State, Zip code

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. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. 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
- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

☑ Other: Agnesian HealthCare, Outpatient Behavioral Health

Address: 430 E. Division Street Phone: (920) 926-4390

Fond du Lac, WI 54935 Fax: (920) 926-8933

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 code)

(Fax number)

For Pick-Ups, please list who will pick-up records:

Name:

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

☑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:____/____/____ (MM/DD/YYYY)

❑ Worker's Compensation Research ❑ Other (specify):

(CONTINUED ON BACK)

ROI

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: BH diagnoses, treatment plan/summary, BH assessments, psychotherapy notes, discharge summary, transfer summary, psychological testing, attendance history, mental status exam

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: _____/_____/_____ to: _____/_____/_____
MM DD YYYY MM DD YYYY

☑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. Disclosure may be in the form of: ☑ Photocopies ☑ Fax ❑ Inspection ❑ CD/DVD ☑ Verbal Disclosure ❑ email: _____

7. EXPIRATION

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

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

8. SIGNATURE

I understand that this authorization is voluntary. I understand that there may be a charge for copies. 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.

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Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

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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 ❑ Mailed first class
❑ Hand carried by ❑ Express mailed ❑ Fax
❑ Other: _____

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

ROI

LABEL

Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
Consultants Laboratory
Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

1.

_____
Name of Patient/Resident

_____
Street Address

_____
City, State, Zip code

_____ _____
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. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

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- ❑ St. Agnes Hospital
- ❑ St. Francis Home
- ❑ Waupun Memorial Hospital
- ❑ Consultants Laboratory
- ❑ Ripon Medical Center
- ❑ Agnesian HealthCare Enterprises
- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

_____

- ☑ Other: Waupun Memorial Hospital Outpatient Behavioral Health

Address: 620 W. Brown Street Phone: (920) 324-7600

Waupun, WI 53963 Fax: (920) 324-8459

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 code)

_____
(Fax number)

For Pick-Ups, please list who will pick-up records:
Name:_____

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

☑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:_____/_____/_____
MM DD YYYY

❑ Worker's Compensation Research ❑ Other (specify):_____

(CONTINUED ON BACK)

ROI

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: BH diagnoses, treatment plan/summary, BH assessments, psychotherapy notes, discharge summary, transfer summary, psychological testing, attendance history, mental status exam

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: _____/_____/_____ (MM/DD/YYYY) to: _____/_____/_____ (MM/DD/YYYY)

☑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. Disclosure may be in the form of: ☑ Photocopies ☑ Fax ❑ Inspection ❑ CD/DVD ☑ Verbal Disclosure ❑ email: _____

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.

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Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

9. Prohibition of Disclosure for Substance Use Disorder: 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. You are entitled to a copy of this authorization after you sign it.

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 ❑ Mailed first class

❑ Hand carried by ❑ Express mailed ❑ Fax

❑ Other: _____

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

ROI

LABEL

Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
Consultants Laboratory
Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

1.

_____
Name of Patient/Resident

_____
Street Address

_____
City, State, Zip code

_____ _____
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. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. 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
- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

  _____
- ❑ Other: _____

  Address: _____

  _____

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:

(If Release is to Self, State Self)

Waupun Memorial Hospital Outpatient Behavioral Health
(Name of Physician/Health Care Facility/Other)

620 W. Brown Street
(Street Address)

Waupun, WI 53963
(City, State, Zip code)

Fax: (920) 324-8459
(Fax number)

For Pick-Ups, please list who will pick-up records:

Name:_____

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

❑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:_____/_____/_____
MM DD YYYY

❑ Worker's Compensation Research ❑ Other (specify):_____

(CONTINUED ON BACK)

ROI

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: BH diagnoses, treatment plan/summary, BH assessments, psychotherapy notes, discharge summary, transfer summary, psychological testing, attendance history, mental status exam

FOR THE FOLLOWING DATE(S) OR TIME FRAME: from: _____/_____/_____ to: _____/_____/_____
MM DD YYYY MM DD YYYY

☑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. Disclosure may be in the form of: ☑ Photocopies ☑ Fax ❑ Inspection ❑ CD/DVD ☑ Verbal Disclosure ❑ email: _____

7. EXPIRATION

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

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

8. SIGNATURE

I understand that this authorization is voluntary. I understand that there may be a charge for copies. 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 (please print): _____ Patient is: ❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

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