AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

990 Main Street , Suite 1 • Baldwin, WI 54002 • Phone 715-629-1888 • Fax 833-434-0364

Patient Information:	Patient name:		Date of Birth:	
	Previous name(s):		MRN:	
	Address:		Phone:	
	City:	State:	ZIP:	

Health Information Released FROM: *(Who has the information you want released?)*	☐ Adoray Home Health & Hospice	☐ Other – Person/Organization:		
	Attn/Department:		Phone:	
	Address:		Fax:	
	City:	State:	ZIP:	

Health Information Released TO: *(Where do you want the information sent?)*	☐ Adoray Home Health & Hospice	☐ Other – Person/Organization:		
	Attn/Department:		Phone:	
	Address:		Fax:	
	City:	State:	ZIP:	

Health Information to be Released: *(What information do you want sent or released? Check the appropriate box)*	Indicate date(s) of service:			
	Routine Record Sets:	☐ Clinic encounter(s)	☐ Hospital encounter(s)	
	Send CHECKED Records only:			
	☐ Communication Notes	☐ Medication Profile	☐ Verbal Orders	*Behavioral Health Specific:*
	☐ Laboratory Results	☐ Flowsheets	☐ Vital Signs	☐ Intake Assessment
	☐ Care Plans	☐ Plan of Care	☐ CTI	☐ Treatment Plan
	☐ Local Coverage Determination	☐ POC Summary	☐ Discharge/Transfer Summaries	☐ Psychological Testing
	☐ Visit Notes	☐ Other:		☐ Psychiatric Evaluation
	All records pertaining to Behavioral/Mental Health, HIV/HIV related illness and Alcohol and/or drug abuse will be released unless indicated here. Do **NOT** release records/information related to:			
	☐ Behavioral/Mental Health	☐ HIV/HIV related illness	☐ Alcohol and/or drug abuse	

Purpose of Disclosure: *(Why is it needed?)*	☐ Continuity/Transfer of Care	☐ Personal use or review	☐ Changing Clinics
	☐ Referral	☐ Insurance or Disability Determination	☐ Dissatisfied with Care
	☐ Legal/Attorney	☐ Other:	☐ Moving Out of Area

Release Instructions: *(How and When do you want the information?)*	Date information is needed:		**(NOTE: PLEASE ALLOW 7 BUSINESS DAYS FOR PROCESSING)**
	Delivery / Format method:		
	☐ Mail – Paper	☐ Pick up – Paper	☐ Fax – Paper

I have read and understand the following rights with respect to this authorization:

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: ______________________
- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. To do so, I may contact Adoray's privacy officer.
- I understand that I am under no obligation to sign this form, however if I agree to sign this authorization, I can be provided with a signed copy of the form upon request.
- I have the right to withdraw this authorization at any time by contacting Adoray's privacy officer in writing. My withdrawal will not be effective as to uses and/or disclosures that Adoray has already made in reference to this authorization.
- I understand that I am under no obligation to sign this form and that Adoray may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this form.
- Adoray cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Adoray from any and all liability resulting from a redisclosure by the recipient.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am authorizing Adoray to disclose my above identified protected health information.

Signature Requirements:		Date:	
	Patient/Legal Representative's Signature (Include relationship if other than patient)		

OFFICE USE ONLY:	**Completion Date:**		**Clinic/Nursing Staff (Initials):**		**ROI/HIM Staff (Initials):**		**Photo ID**	