AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

990 Main Street, Suite 1● Baldwin, WI 54002 ● Release of Records Representative● Phone 715-629-1888 ● Fax 866-487-2984

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| --- | --- | --- | --- | --- | --- | --- |
| **Patient Information:** | Patient name: \_\_\_\_\_\_\_\_ DatDa | | | | ate of Bi | rth:\_\_\_\_\_ |
| Previous name(s): |  |  | MRN: | |  |
| Address: |  |  | Phone: | |  |
| City: |  |  | State: |  | ZIP: |
| **Health Information Released FROM:**  ***(Who*** *has the information you want released?)* |  Adoray  **OR** | |  |  |  |  |
|  Other – Person/Organization: | | | | | |
| Attn/Department: |  | Phone: | | | |
| Address: |  |  | Fax: | |  |
| City: | | | State: | | ZIP: |
| **Health Information Released TO:**  ***(Where*** *do you want the information sent?)* |  Adoray  **OR** | |  |  |  |  |
|  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: |  Hospice encounter(s) | |  Home Health encounter(s) | |  |
| Send CHECKED Records only: | | |  |  |  |
| * Plan of Care * Plan of Care summary * Local Coverage Determination * Progress Notes | * Communication Notes * Verbal orders * Pathology reports * Lab Results * Rehab records (PT/OT/ST) | | * Medication Profile * Flow Sheets * Billing Records * Certification of Terminal Illness * Other: | | * Vital Signs * Discharge/Transfer Summaries * Visit Notes |
| 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 * Referral * Legal/Attorney | | * Personal use or review * Insurance or Disability Determination * Other: | | * Changing Clinics * Dissatisfied with Care * 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 * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * Pick up – Paper | | * Fax – Paper * Email – Encrypted P | |
| **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:** |  | | | |  | |
| Patient/Legal Representative’s Signature (include relationship if other than patient) | | | | Date | |

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

3/2021 kd