



Office Use Only: MR# _____		
Org# _____		
Request Received: Date _____	Time _____	Initials _____
Request Completed: Date _____	Time _____	Initials _____

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION**

Name of Person requesting records: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**Regarding:**

Name:	Birthdate:	
Address:	Telephone:	
City:	State:	Zip Code:

**Records Released From:**

**Records Released To:**

<b>Monroe Clinic</b>	Name - (Insurance Co., Lawyer, Physician, Individual, etc.)
515 22 <sup>nd</sup> Avenue	Address
Monroe WI 53566	City, State, Zip

\_\_\_ Check if patient/ authorized rep. requests records to be faxed. Fax number \_\_\_\_\_

**Indicate facility(s) records are being requested from:**

\_\_\_ Clinic Records    \_\_\_ Hospital Records    \_\_\_ Other: \_\_\_\_\_  
 \_\_\_ Site Office Records, Indicate Site(s): Albany    Brodhead    Blanchardville    New Glarus    Durand    Freeport    Lena

**Type or extent of information to be disclosed: (Check all that apply)**

Visit Date(s): \_\_\_\_\_ Telephone Request \_\_\_ Pick up Date: \_\_\_\_\_

- |                            |                                 |                       |                        |
|----------------------------|---------------------------------|-----------------------|------------------------|
| ___ History/Physical Exams | ___ Progress Notes              | ___ ER Record         | ___ Occup. Therapy     |
| ___ Discharge Summary      | ___ X-ray Reports               | ___ X-ray Films       | ___ Physical Therapy   |
| ___ Laboratory Reports     | ___ Procedure/Pathology Reports | ___ Electrocardiogram | ___ Speech Therapy     |
| ___ Immunizations          | ___ Allergy Records             | ___ Prescriptions     | ___ Condition to media |
- \_\_\_ Account information (patient name/address, responsible party name/ address, insurance company name, policy number)

\_\_\_ Other: \_\_\_\_\_

According to Wisconsin State Statutes, the categories listed below require special permission for release. Please indicate for any of the following items that you wish to be released instead of or in addition to the items indicated above.

- |                      |                                |   |
|----------------------|--------------------------------|---|
| ___ Mental Health    | ___ Developmental Disabilities | ___ Alcohol/ Drug Records   |
| ___ HIV Test Results | ___ HIV Treatment records      | ___ Sexually Transmitted Disease Test Results and Treatment Records |

**Purpose or need for disclosure: (Check all that apply)**

- |                                 |                               |                   |                     |
|---------------------------------|-------------------------------|-------------------|---------------------|
| ___ Further medical care        | ___ Application for insurance | ___ Personal      | ___ Law Enforcement |
| ___ Payment of insurance claim  | ___ Disability determination  | ___ Legal         | ___ Inspection      |
| ___ Medical Equipment/ Supplies | ___ Ambulance Service         | ___ Media Release |                     |
- \_\_\_ Other: \_\_\_\_\_

Please be aware that any time your medical information is being released for further medical care, your medication records will automatically be forwarded with the requested information.

**Page 2 must also be completed**

**A COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE PATIENT AT THE TIME THE PATIENT COMPLETES THE AUTHORIZATION. (front and back)**

I understand that if the person(s) and/or organization(s) listed above as the recipients of my protected health information are not health care providers or health plans (health insurance companies) that the information I am authorizing the release of may no longer be protected by the federal or state privacy standards and my health information may be re-disclosed without obtaining my authorization.\*\* I will hold harmless Monroe Clinic and all of its branch offices from and against any and all liability in connection with the disclosure of protected health information as authorized herein. I understand I may inspect and arrange for photocopies of the information that will be disclosed as a result of this authorization. This authorization will remain in effect to carry out the purpose for which it is intended, but will not remain in effect for dates of medical service beyond the stated expiration date. I understand that I may revoke this authorization at any time (except to the extent action has already been taken in good faith reliance on this authorization) by submitting a written request to Monroe Clinic. If I refuse to sign this authorization, my medical records/ information will not be released.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Authorized Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Witness Signature (if applicable)

\_\_\_\_\_  
Expiration Date of Authorization  
(will default to one year from date signed if no expiration date is given)

Please note that regardless of expiration date, information will only be released for dates of medical service performed on or before the date of the signature of the patient or authorized person.

**Relationship of Authorized Person Signature:**

Parent       Legal Guardian       Executor of Estate of Deceased  
 Power of Attorney for Healthcare\*       Authorized Legal Representative\*       Court Appointed Temporary Guardian

**Patient is:**       Minor       Incompetent       Disabled       Deceased       Incapacitated

\*Must have written proof that representative is Power of Attorney for Healthcare or Authorized Legal Representative and the document must state that the Authorized Person may obtain and / or sign for legal papers and/ or medical information. The patient must be legally incapacitated in order for the Power of Attorney for Healthcare to sign in place of the patient.

\*\* **Exception: Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) indicate that those records are protected and cannot be disclosed or re-disclosed without the individual patient's written consent unless otherwise provided for in the regulations.**

**NOTICE TO RECIPIENT OF INFORMATION:** This notice may accompany a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal Confidentiality rules 42 CFR Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is 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.

**RIGHTS:**

- ❖ **Right to Inspect or Copy the Information to be Used or Disclosed.** 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.
- ❖ **Right to Receive Copy of This Authorization.** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy.
- ❖ **Right to Refuse to Sign This Authorization.** I understand that I am under no obligation to sign this form and that the person(s) and/ or organization(s) listed above who I am authorizing to use and/ or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization.
- ❖ **Right to Withdraw This Authorization.** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Monroe Clinic Medical Records Department. I am aware that my withdrawal will not be effective for uses or disclosures made previous to my withdrawal.

**A COPY OF THIS FORM IS AS VALID AS THE ORIGINAL.**