

PROVIDER CORRESPONDENCE AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Page 1 of 2

Patient Name: _____

Date of Birth: _____

MRN: _____

PATIENT / AUTHORIZED REPRESENTATIVE:

Both pages of this authorization must be completed in full or could result in delays in processing.

Patient Name: _____ Phone: _____ CELL WORK HOME

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____

I authorize the use or disclosure of the above named patient's Protected Health Information as described below from Wheaton Franciscan Healthcare/Wheaton Franciscan Medical Group including all current and treating physicians, medical practitioners and healthcare providers for the diagnosis, conditions and/or illnesses listed below:

Diagnosis/Condition/Illness: _____

Treating Physician(s): _____, _____, _____

Date of Injury/First Symptom: _____

First Day off Work (Physician Authorized): _____

Approximate or Actual Return to Work Date (Physician Authorized): _____

Are you Scheduled for/or have you had any Surgery? Yes No If yes, Date of Surgery: _____

Family Leave Forms: If this request is also for a family leave form, please provide the following information: (will the leave be on an intermittent basis, indicate the number of hours per day/week/month and/or dates if applicable. Also include any other additional information that you feel would be helpful in completing your form/request).

UPON COMPLETION OF THE FORM:

Call for Pickup: _____ Phone Number: _____

(If you requested a call for pickup and we have made several attempts to reach you with no success, your form/request will be mailed to you)

Mail To: (Name of Company/Requestor): _____ Address: _____
City: _____ State: _____ Zip Code: _____

Fax Form To: (Name of Company/Requestor) _____
Attn: _____ Fax # with Area Code: (_____) _____

(Follow-ups requested from the company(s) listed above may also be faxed, mailed or called-in as needed)

Confirmation Call: _____ Phone Number: _____

If you would like another person(s) to be authorized to call, pickup or discuss the status or disclosure of the form/requests regarding the diagnosis/condition/illnesses listed above, please complete the following:

Name of Person Authorized: _____ Relationship: _____



**Provider Correspondence
Authorization to Disclose Health
Information**

File: ROI / Correspondence

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Name _____

Date of Birth _____

Chart ID _____

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Page 2 of 2

Patient Name: _____

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This authorization is voluntary; Wheaton Franciscan Healthcare/Wheaton Franciscan Medical Group will not condition your treatment on this authorization. A copy of this authorization will be considered as valid as the original.

The purpose of this authorization is for the completion of disability, family leave forms or correspondence/miscellaneous requests relating to the diagnosis/condition/illnesses listed on Page 1 of this authorization.

I understand that I have a right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the Health Information Department. I understand that my revocation will not apply to information that has already been released in response to this authorization.

I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected by such laws.

In support of your privacy, this authorization will be valid from the first symptom/date of treatment and for the entire length of the diagnosis/condition listed on previous page, but no longer than 365 days from the date of this authorization. I understand that if I refuse to authorize the disclosure of information, the information may not be released. Refer to the Notice of Privacy Practices for more information about your rights with your Protected Health Information.

I understand that the information in my health record may include information relating to mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that if I refuse to authorize the disclosure of information, the information may not be released.

I further understand that HIV test results may be disclosed without my permission in certain circumstances and that a list of such circumstances is available to me upon request.

I further understand that I have a right to receive a copy of any mental health treatment record to be disclosed.

This authorization expires 365 days from the date this authorization is signed unless otherwise noted _____

Signature of Patient or Authorized Representative: _____ **Date:** _____

For Office Use: Identification Verified: _____ (Initials) Signature Verified: _____ (Initials) Dept: _____ Site: _____

If Signed by Authorized Representative, Relationship to Patient: _____

(If you are signing as a parent of the minor patient listed above, you are declaring that you have not been denied physical placement or parental rights of the child because such placement would endanger the child's physical, mental or emotional health.)

Witness Signature (when applicable): _____ Date: _____

If unable to sign document, give reason: _____

COMPLETE THIS SECTION AT TIME OF PICK-UP

Signature of Patient or Authorized Representative

Date

If Signed by Authorized Representative
Relationship to Patient

For Office Use: Identification Verified: _____ (Initials)
Dept: _____

Signature Verified: _____ (Initials)
Site: _____



**Provider Correspondence
Authorization to Disclose Health
Information**

File: ROI / Correspondence

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