

AUTHORIZATION TO VIEW/DISCLOSE HEALTH INFORMATION

Last Name (& Maiden, if applicable): _____ First: _____ MI: _____

Address: _____

Date of Birth: _____ Sex: _____ Phone Number: _____

I authorize the use or disclosure of the above named patient's health information as described below:

FROM: Name: _____ Address: _____ _____ City, State, Zip: _____ Fax Number: _____	TO: Name: _____ Address: _____ _____ City, State, Zip: _____ Fax Number: _____
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FOR THE PURPOSE OF: (Check all that apply.)

- Transfer of Primary Care
 Continued Specialty Care
 Second Opinion
 Legal
 Insurance
 Personal Use
 Other: _____

INFORMATION TO BE VIEWED AND/OR DISCLOSED:

- Date(s) of Treatment: _____ Schedule Appointment to View Record Only (no copies)
 Record Abstract (two-year history of pertinent information unless otherwise stated above)
 Discharge Summary
 History & Physical
 Emergency Record
 Operative Record
 Progress Notes
 Lab Results, date or type: _____
 X-ray Reports, date or type: _____
 Immunization Record
 Other: _____

PLEASE CHECK IF YOU DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:

- HIV/AIDS (including test results)
 Substance Abuse Record
 Mental Health Treatment Records

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.

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. 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 Health Information Services. I understand that my revocation will not apply to information that has already been released in response to this authorization.

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

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

Signature of Patient or Authorized Representative: _____ Date: _____

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: _____



Patient Access to Health Information

“As a patient at Wheaton Franciscan Healthcare, you have the right, consistent with laws and regulations, to see and receive a copy of health information about yourself.”

ACCESSING YOUR MEDICAL RECORDS

APPOINTMENT TO VIEW YOUR MEDICAL RECORDS: An appointment to view your medical records can be arranged by calling the Release of Information Area. Appointments are scheduled during regular business hours as soon as possible but may be delayed if your record is not available.

REQUESTING COPIES OF INFORMATION: An Authorization To View/Disclose Health Information must be filled out and sent to Release of Information before we can copy your records.

Once the authorization is filled out, you can send it to Release of Information by:

- Drop off: Authorizations are accepted during regular business hours. Please bring a photo id when dropping off authorizations.
- Mail: Authorizations may also be mailed to the addresses listed below. Please include a copy of a photo id or include a notarized signature.

*We are unable to accept authorizations via e-mail due to state and federal laws.

A fee of \$0.31 per page is charged to patients to cover the costs of copying along with sales tax and actual postage. As a courtesy to our patients, records are copied free of charge if records to facilitate care when they are delivered directly to a referring or consulting physician. Additional fees may apply if records are delivered to someone other than the patient or physician.

Upon payment, copies of medical records will be mailed or may be picked up during regular business hours. A photo id is required when picking up copies of medical records.

INSTRUCTIONS FOR COMPLETING AN AUTHORIZATION TO VIEW/DISCLOSE INFORMATION

Obtain the form from the Release of Information Departments or via the Wheaton Franciscan Healthcare website. Please read the entire form to understand your rights. All items must be answered completely in ink.

PATIENT NAME, PHONE, ADDRESS, DATE OF BIRTH, SOCIAL SECURITY NUMBER: Accurately enter the patient's demographic information.

FROM: Enter the Name, Address, City, State, and Zip of where the facility you are seeking records from. (i.e. WFMG)

TO: Enter the Name, Address, City, State, and Zip of where the records are to be mailed. If you would like to pick up medical records, simply write "Call for pick up" in this location.

FOR THE PURPOSE OF: Check the reason for the request. If the reason is not listed, check the "Other" box and write in the reason.

INFORMATION TO BE VIEWED AND/OR DISCLOSED: If you are requesting to view your medical records, simply check the "View Entire Record" box. If you are requesting copies, enter the dates of service you are requesting records from on the first line. In addition, check the documents that you are requesting from this timeframe. If what you are looking for is not listed, check the "Other" box and write in the information.

SENSITIVE INFORMATION: State and federal laws protect records regarding HIV, Substance Abuse, and Mental Health at a higher level. If there is information listed that you do not want released to the person indicated, please check the box. Otherwise, leave blank.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE: The patient must sign the authorization unless one of the following applies:

- Patient is Incapacitated: Statement of Incapacitation signed by two physicians must accompany the authorization which can be signed by the Power of Attorney for Healthcare or spouse. If there is no Power of Attorney for Healthcare or spouse, any member of the immediate family may sign.
- Patient is Deceased: The surviving spouse must sign. If there is not a surviving spouse, any member of the immediate family may sign.
- Patient has a Legal Guardian: The legal guardian appointed in a court of law must sign.
- Patient is a Minor: Access to records of minors have the following guidelines:
 - Either of the parents may sign as long as they were not denied parental rights *by a court of law*.
 - Release of sensitive information varies based on diagnosis and age. In some circumstances, the minor's signature is required for release of records; in others, the parent's signature is required for release of records.
 - Other exceptions apply to minor records and are handled on a case-by-case basis.

If the authorization is not signed by the patient, please indicate the relationship to the patient.

**Please note: Spouse, step-parents, foster parents, birth parents of children placed for adoption, personal representatives, and durable power of attorneys are not authorized by law to sign for copies of records.*

DATE: Enter the date you are signing the form.

