AUTHORIZATION TO VIEW / DISCLOSE HEALTH INFORMATION

3 R O I

Patient Name _____ MR Number _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____ Phone _____

I authorize the use or disclosure of the above named patient's Protected Health Information as described below:

FROM:

WHEATON FRANSICAN HEALTHCARE:

Wheaton Franciscan:
☐ Elmbrook Memorial Campus ☐ St. Joseph Campus
☐ The Wisconsin Heart Hospital Campus

Wheaton Franciscan Healthcare:
☐ Franklin ☐ St. Francis ☐ St. Michael

OTHER:

_____

_____

TO:

Name _____

Address _____

City _____ State _____

Zip _____

Fax Number _____

FOR THE PURPOSE OF: (Check all that apply.)

☐ View Protected Health Information ONLY: Date _____ Time _____

☐ Continued Care ☐ Legal ☐ Insurance ☐ Personal Use ☐ Other _____

INFORMATION TO BE VIEWED AND OR DISCLOSED:

Date(s) of Service: _____ **to** _____ **or Type:** _____

☐ Record Abstract (two year history of pertinent information unless stated above)

☐ Discharge Summary ☐ History & Physical ☐ Operative Record ☐ Lab Results

☐ Emergency Record ☐ Immunization Record

☐ Radiology Reports/Images, dates or type: _____

☐ 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 this information, the information may not be released.

I 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 inspect or receive a copy of any health information used or disclosed. I understand that if I sign this authorization, I will be provided with a copy of this authorization upon request.

In support of your privacy, WFH does not accept your blanket authorization to disclose Protected Health Information for treatment you have not yet received unless the authorization specifically requests release of information of further treatment of the condition treated in the originally requested episode. A new authorization will be required for each new episode of care.

PATIENT LABELS MUST BE PLACED HERE ON ALL PAGES (PARTS) – SIDES OR FOLD-OUT (PANELS) THAT THIS BOX APPEARS ON.

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.

This authorization expires 365 days from the date it is signed by the patient unless otherwise noted _____.

This authorization is voluntary. Wheaton Franciscan Healthcare will not condition your treatment on this authorization.

_____ _____ _____

Signature of Patient or Authorized Representative | Date | Time

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

If signed by other than patient, indicate relationship or authority:

Patient is: ☐ a Minor ☐ Incompetent ☐ Deceased

I am: ☐ Parent ☐ Legal Guardian ☐ Next of Kin of Deceased ☐ Executor of Estate

☐ POA for health care (activated)

_____ _____ _____

Signature of Witness | Date | Time

If unable to sign document, give reason _____

NOTE: "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 expressly 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."

OFFICE USE RELEASE LOG

Identification Verified: _____ (initials) Signature Verified: _____ (initials) Date: _____ Time: _____

Route of Release: ☐ Fax ☐ Mail ☐ Pick-up ☐ Patient notified of applicable fees

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