

ProHealth Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-262-928-4465 (VRS: 1-866-327-8877).
 ATENCIÓN: Si habla español, tenemos a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-262-928-4465 (VRS: 1-866-327-8877).
 LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-262-928-4465 (VRS: 1-866-327-8877).

PATIENT INFORMATION:

Name of Patient/Previous Names _____ Birth Date _____ Medical Record Number _____

Street Address _____ City, State, Zip _____ Phone Number _____

AUTHORIZES DISCLOSURE BY:

ProHealth Care Oconomowoc Memorial Hospital ProHealth Care Waukesha Memorial Hospital
 ProHealth Care Behavioral Health Services ProHealth Medical Group Occ Health, Specify Site _____
 PHMG, Specify Clinic/Provider _____ ProHealth Solutions Participant _____
 Other (Name of Health Care Provider/Plan/Other): _____
 Street Address _____ City, State, Zip Code _____

DISCLOSURE OF HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other _____
 Street Address _____ City, State, Zip Code _____

INFORMATION TO BE DISCLOSED:

CLINIC		HOSPITAL	
<input type="checkbox"/> Clinic Records 2-3 Year Summary (general abstract includes Progress Notes, Consults, Labs & Radiology Reports)		<input type="checkbox"/> Hospital Summary (general abstract includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports and ED Report)	
<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Mental/Behavioral Health	<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Mental/Behavioral Health
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Radiology Films	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Radiology Films
<input type="checkbox"/> Office Visit Notes	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Radiology Report
<input type="checkbox"/> Operative/Procedure Report	<input type="checkbox"/> Rehab Notes (PT, OT, Speech)	<input type="checkbox"/> Consultation	<input type="checkbox"/> Rehab Notes (PT, OT, Speech)
<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Billing Records	<input type="checkbox"/> Operative/Procedure Report	<input type="checkbox"/> Billing Records
<input type="checkbox"/> Pathology Report		<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Other _____		<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Pathology Report
		<input type="checkbox"/> Other _____	

DISCLOSURES REQUIRING SPECIAL CONSENT: In compliance with Wisconsin Statutes and federal law, which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed.

Check all that apply. HIV/AIDS* Substance Use Disorder SANE SANE Photos

All information, including the information listed as "Clinic" and "Hospital" above, will be disclosed under this authorization, except: _____ (please list information).

FOR THE FOLLOWING DATES: From: _____ To: _____

PURPOSE FOR DISCLOSURE: Please provide specific purpose for disclosure or check applicable category.

Continuing Care Transfer to New Provider Insurance/Claim Purposes Legal Personal Use
 Disability Determination Workers Compensation Vocational Rehab Eval
 Other _____

Check One: Verbal Release Paper Release View Electronic/Digital Release (specify) _____

Release by: US Mail MyChart Fax _____ Pick-Up: Location _____

PATIENT LABEL



YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Receive a Copy of the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) of 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, I may receive a copy.

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that ProHealth Care may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to ProHealth Care's Release of Information Department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organizations(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards.

***HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State laws and a list of those persons/organizations is available upon request.

Copy or Facsimile (FAX) Valid as an Original.

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.

EXPIRATION DATE: This authorization is effective until _____ or 6 months from the date signed, and includes records that were created or existed on or before the date this authorization was signed.

This includes records that are created after the date this authorization is signed, up until the expiration date.
_____(initials)

SIGNATURE OF PATIENT/LEGAL REP: _____ **DATE:** _____ **TIME:** _____

If signed by a person other than the patient, complete the following:

1. Individual is: a minor legally incompetent or incapacitated deceased
2. Legal authority: parent* legal guardian next of kin/executor of deceased activated POA for Health Care

*By signing above, I hereby declare that I have not been denied physical placement of this minor child.

Information Released By: _____ **DATE:** _____ **TIME:** _____

Number of Pages Released: _____

PATIENT LABEL

