SSMHealth

Mail to: Health Information Management
515 22nd Ave – Monroe, WI 53566
Email to: MON-release.of.info@ssmhealth.com
Fax to: (608) 324-1148 Phone: (608) 324-2270

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Information:

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

Released by: **Monroe Clinics and Hospital (or)** **Send to:**

Name (e.g. Health Facility, Physician)	**Name (e.g. Insurance, Lawyer, Physician, Patient)**
Address	**Address**
City, State, zip	**City, State, Zip**
Phone **Fax**	**Phone** **Fax**

Date of upcoming appointment (if applicable): _____ Pick up date: _____

___ Paper ___CD ___ Patient Portal (MyChart) ___ Email_____

Visit Dates to be released: _____

Type or extent of information to be released: (check all that apply)

__ Progress notes __ History/Physical Exams __ ED Notes __ Med List
__ Discharge Summary __ X-ray Reports __ X-ray Films/CD __ Problem List
__ Laboratory Reports __ Procedure/Pathology Reports __ Electrocardiogram __ Phy Therapy
__ Immunization __ Allergy Records __ Prescriptions __ Occ Therapy
__Account Information (patient name/address, responsible party name/address, ins.co. name. policy number) __ Speech Thrpy
__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 for 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 & Treatment Records

Purpose or need for release: (check all that apply unless for personal use)
Note: There may be a charge for copies of Medical records for purposes other than further medical care.

__ 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: _____

Updated 5/20

Office Use Only:
MRN #:_____
Completion Date/Initials_____

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 The 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 if I do not specify an expiration date, the authorization will expire in one year. 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 The Monroe Clinic. If I refuse to sign this authorization, my medical records/ information will not be released.**

_____ **Date** _____
Signature of Patient (must be 18 years of age or older)

_____ **Date** _____
Signature of Authorized Person

_____ **Date** _____
Signature of Witness (Required for IL Mental Health)

This authorization will expire on the following date: _____.
***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:

___ Custodial 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 The 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.