SSM Health

SSM Health Dean Medical Group
SSM Health Surgery Center
SSM Health Digestive Health Center
SSM Health St. Mary's Hospital – Madison
SSM Health St. Mary's Hospital – Janesville
SSM Health St. Clare Hospital – Baraboo

❑ SCAN ONLY-No additional information needed

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in full. See reverse side for important information)

1.

Name of Patient

Street Address

City, State, Zip code

Date of Birth Phone #

I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization by providing written notice to SSM Health. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. AUTHORIZE:

SSM Health
(Name of Physician/Health Care Facility/Other)

PO Box 259840
(Street Address)

Madison, WI 53725-9840
(City, State, Zip code)

SSM Health Dean Medical Group 608-294-6294 (Fax)

SSM Health Hospitals 608-270-6815 (Fax)

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:
(If Release is to Self, State Self)

(Name of Physician/Health Care Facility/Other)

(Street Address)

(City, State, Zip code)

(Fax)

4. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

❑ Continuing Care ❑ Transferring Care (Customary to release last 2 years of information. Release may occur electronically)

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt Date ____/____/____ (MM/DD/YYYY)

❑ Worker's Compensation Research ❑ Other (specify):_____

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam

❑ Operative Reports ❑ Immunization Records ❑ Lab Reports ❑ Imaging Reports

❑ Medical Images (specify) _____ ❑ Billing Records (specify) _____

❑ Specific information related to: _____

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: ____/____/____ (MM/DD/YYYY) To: ____/____/____ (MM/DD/YYYY)

5a. This authorization includes disclosure of information regarding mental health, alcohol and/or drug abuse, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. FORMAT FOR RECORDS: ❑ MyChart ❑ DVD/CD ❑ Paper ❑ Verbal Disclosure ❑ Fax
❑ Email to: _____

7. EXPIRATION

This authorization will expire on ____/____/____ (MM/DD/YYYY). If I do not indicate a date, this will expire one (1) year from the date of my signature below. A photocopy of this authorization is as valid as the original.

8. SIGNATURE

I understand that this authorization is voluntary. I understand that there may be a charge for copies. I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature:_____ Date:_____

If this Authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____ Patient is: ❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ❑ Parent of MInor ❑ Spouse of Deceased ❑ Health Care Agent _____
❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

ADDITIONAL INFORMATION REGARDING RELEASE OF HEALTH INFORMATION

SSM Health recognizes the patient's right to confidentiality of their health information under federal privacy regulations and Wisconsin law. The patient should be aware of the following information when requesting or releasing health information.

- **Record Definition:** The record(s) defined for release include record(s) generated at all SSM Health locations.
- **Right to Refuse to Sign This Authorization:** A patient may refuse to sign this Authorization and this refusal will not affect the patient's ability to obtain treatment or payment of claims.
- **Right to Inspect or Copy the Health Information to Be Used or Disclosed:** A patient has the right to inspect or copy the health information they have authorized to be used or disclosed by signing this Authorization form. A patient may arrange to inspect their health information by contacting the office listed below.
- **Right to Receive Copy of This Authorization:** A patient has the right to receive a copy of the signed Authorization form.
- **Right to Revoke This Authorization:** A patient has the right to revoke this Authorization at any time by giving written notice of revocation to the Privacy Officer listed below. Revocation of this Authorization **will not** affect any action taken in reliance of this authorization before receipt of the written notice of revocation.
- **Multiple Releases of Information:** A patient may request multiple releases of the information stated on the Authorization form as long as the authorization is not expired.
- **Who May Sign This Authorization:**
  1. Generally, all patients 18 years of age and older must sign for release of their own health information unless the following conditions apply.
     a. The patient is incompetent
     b. The patient is disabled and cannot sign the form
     c. The patient is deceased. (A surviving spouse or personal representative of the estate may sign. If there is no surviving spouse or personal representative, then an adult member of the immediate family may sign.)
  2. All persons signing for release of health information on behalf of the patient must state their relationship to the patient and provide proof of legal authority of their capacity to act for the patient.
  3. Minors: Patients less than 18 years of age must sign for release of their health information in the following cases:
     a. Alcohol or other drug abuse treatment: age 12 or older
     b. Mental health treatment: age 14 or older may consent to release of records without parental consent (Parents also retain the right to access this information.)
     c. HIV test results: age 14 or older
     d. Emancipated minors who are married or in the military
- **Fees for Records:** SSM Health may charge a reasonable fee for viewing, copying, postage and preparation of records to fulfill this request. All fees are based on the applicable laws governing release of health information.
- **Contact Office:**
  1. Requests for **release of health information** can be directed to Health Information or you may call our main office at:

     608-294-6244
     SSM Health Dean Medical Group
     ATTN: Release
     PO Box 259840
     Madison, WI 53725-9840

     OR

     608-270-6806
     SSM Health Hospitals
     ATTN: Release
     PO Box 259840
     Madison, WI 53725-9840

  2. All **questions regarding federal privacy regulations** can be directed to:

     SSM Health Privacy Officer
     1808 W. Beltline Highway
     Madison, WI 53713
     Telephone: 608-250-1075
     E-Mail: PrivacyOfficer@ssmhealth.com