ProHealth Solutions

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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

ProHealth Solutions

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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 Solutions Participant 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 Solution'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