ROGERS Behavioral Health
34700 Valley Road, Oconomowoc, WI 53066
PHONE: 800-767-4411, option 3 FAX: 262-646-5745 WEBSITE: rogersbh.org

Authorization to Release Protected Health Information

1. Patient Information:

First Name | Middle Initial | Last Name | Former Name(s) | Date of Birth

Street Address | City | State | Zip | Phone Number

2. I authorize (check all that apply)**:**

□ Rogers Behavioral Health – California □ Rogers Behavioral Health – Florida □ Rogers Behavioral Health – Georgia
□ Rogers Behavioral Health – Illinois □ Rogers Behavioral Health – Minnesota □ Rogers Behavioral Health – Pennsylvania
□ Rogers Behavioral Health – Tennessee □ Rogers Behavioral Health – Washington □ Rogers Behavioral Health – Wisconsin

3. □ To Release To: □To Obtain From:

Agency/Facility/Person | Phone Number | Fax Number

Street Address | City | State | Zip

4. Information to be Released: Dates of Service: _____ □ Entire Record
If no end date entered, will continue to apply through date of expiration of this authorization

□ Psychiatric Evaluation □ Discharge Summary □ Treatment Plans □ Clinical Summary
□ Medication List □ Education Planning □ Discharge Instructions □ History & Physical/Consult
□ Date of Service Letter □ Safety Plan □ Other: _____

**For continuing care purposes, an abstract will be sent (Discharge Summary, Psychiatric Eval, History & Physical/Consults, Medications)*

5. Type of Information: I understand that the information to be released may include information regarding genetic testing, substance use disorder, HIV test results, and sexually transmitted infections. (*check below if you do **not** want this information released):*
□ Substance Use Disorder Treatment □ HIV test results and related treatment □ Sexually transmitted infections □ Genetic Testing

6. Method of Delivery: (check one)
□ US Mail □ Fax □ Digital Flash Drive □ Secure Email: _____ □ Verbal

7. Purpose of Disclosure: (check all that apply)
□ Continuing Care □ Legal □ Education Planning □ Personal □ Insurance eligibility/payment □ Verify compliance with treatment
□ Other: _____

8. Expiration: This authorization will expire at midnight one year from the date of my signature below unless otherwise designated. Other expiration date, time period, or event: _____ This authorization will apply to health records generated during the time frame specified above up to the date of expiration of the authorization and will include financial information related to this account until the close of the account.

9. Patient Rights Regarding This Authorization:
I authorize the release of the health information described above. By signing this form, I am authorizing the release of all records applicable to this request that are maintained as part of Rogers' health record regarding me. I understand that I may revoke this authorization; I must do so in writing and present the Cancellation of Authorization Form HIM-056) to the Health Information Department. I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage. I understand I may be charged a fee for preparing and delivering the records to fulfill this request. I understand that Rogers may not condition treatment, payment, enrollment, or eligibility for benefits upon execution of this authorization unless the services are being provided solely for the purpose of releasing the information to a third party. I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by the HIPAA Privacy Regulations, but that all recipients of information related to alcohol and drug abuse patient records are informed of the prohibition against disclosure as required by the Confidentiality Regulations found at 42 C.F.R. Part 2. I understand that I have a right to a copy of this authorization and that I have the right to a inspect or receive a copy of the material to be disclosed as required under Wisconsin §§ DHS 92.05 and 92.06. I understand that a photocopy/facsimile copy of this document is as valid as the original form.

10. Authorization:

_____
Signature of Patient **Date/Time**

_____
Signature of Legal Representative **Date/Time**

If patient is unable to sign, give reason: _____

Witness Print Name & Date: _____

If signed by a person other than the patient, patient is:
□ a minor □ legally incompetent or incapacitated □ deceased

Legal Authority: □ parent □ legal guardian □ activated power of attorney for healthcare (If you are signing as a parent of a minor patient, you are declaring that you have not been denied physical placement or parental rights of the child because such placement would endanger the child's physical, mental, or emotional health)

Comments (optional)**:** _____

Redisclosure Notice for Recipient of Information: If this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2), 42 CFR part 2 prohibits unauthorized disclosure of these records.

For office use: Signature verified: _____ (initials)