INSTRUCTIONS FOR COMPLETING AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1	Check appropriate box for authorization to disclose to or obtain from.
2	Print patient's name. Include previous names, if applicable and also date of birth.
3	Patient's street address including city, state and zip code.
4	Patient's home phone. Helpful if we need to contact.
5	Print name of person or organization and include address that will be receiving the information. If the patient is the recipient then print the patient's name and address. Include recipient's phone number and fax number. NA if phone or fax number is not available. *Note*: If patient is a minor and the parents are receiving the information, then print the parent's name(s).
6	Be specific in this section and only check the documents that are needed to fulfill the release. *Note 1*: ONLY check billing records if they are specifically being requested *Note 2*: When using the "other" box you must fill in the type of document requested
7	Include dates of service for the documents being requested. For patients transferring care to another organization it is acceptable to write in "last 2 years of records". ***Note:*** Do not leave this section blank. This release is only good for dates of service up to the date it was signed unless otherwise specified in this area. It is very important that HI be able to document exactly what was released. A fee may be applied for entire medical record.
8	Check appropriate boxes if sensitive/HIPAA protected information is being requested.
9	Check either paper release or electronic release.
10	Check appropriate box to indicate the purpose of disclosure.
11	Patient must sign document. *****
12	Patient must date document after they signed.
13	Legal representative (i.e. parent, guardian, POA) signature if needed.
14	Legal representative must date document after they signed.
15	If signed by legal representation, relationship to patient must be specified.
16	Processing/witness request

Contact the Rogers Memorial Health Information department with questions:

(All sections must be completed)

1-800-767-4411 select option "3"

* 51.30 Minor who is aged 14 or older may consent to the release of confidential information without the consent of the minor's parent, guardian or person in the place of a parent. The parent, guardian or person in the place of a parent of a developmentally disabled minor shall have access to the minor's court and treatment records at all times **except in the case of a minor aged 14 or older who files a written objection to such access with the custodian of the records**. **Substance Abuse Treatment records** 51.47 and 42CFR 2.14 confidential information can only be released with consent of a minor patient, provided the minor is 12 years of age or older.

Authorization for Disclosure of Protected Health Information

Rogers Behavioral Health
1-800-767-4411 select option "3"
Fax 1-262-646-5745

PLEASE COMPLETE ALL ITEMS ON THE FORM OR WE CANNOT RELEASE *If you have questions contact the above number.*

I authorize Rogers Behavioral Health to: ☐ Disclose to: ☐Obtain from: 1

1. PATIENT INFORMATION:

2

PATIENT NAME | **PREVIOUS NAME** | **DATE OF BIRTH**

3

PATIENT STREET ADDRESS

CITY | **STATE** | **ZIP CODE**

4

HOME TELEPHONE | **WORK TELEPHONE**

2. FACILITY NAME RELEASE TO / OBTAINED FROM:

5

AGENCY/FACILITY/PERSON | **RELATIONSHIP TO PATIENT**

STREET ADDRESS

CITY | **STATE** | **ZIP CODE**

TELEPHONE NUMBER | **FAX NUMBER**

3. SPECIFY THE INFORMATION TO BE DISCLOSED EITHER VERBALLY OR IN WRITING: 6

☐ **THE FOLLOWING INFORMATION CONTAINED IN MY HEALTH RECORD:**

☐ Psychiatric Evaluation/Findings ☐ Psychological Findings ☐ Legal Status/Court Records
☐ Medications ☐ Psychosocial Assessment (PSA) ☐ Treatment Plans
☐ History & Physical/Medical Evaluation ☐ Educational Planning Information ☐ Laboratory/Radiology/EKG reports
☐ Personal Recovery Plan / Discharge Instructions ☐ Discharge Summary ☐ Other:

☐ **ENTIRE MEDICAL RECORD FOR THE FOLLOWING DATE(S) OF SERVICE FROM** _____ 7 **TO** _____

For continuing care purposes, an Abstract will be sent including Discharge Summary, Psychiatric Findings, History &Physical, Consultations, Medications, Personal Recovery Plan (Discharge Instructions) and Diagnostic tests (Lab, X-ray, EKG) if performed.

4. THE FOLLOWING INFORMATION WILL NOT BE RELEASED UNLESS SPECIFICALLY CHECKED BELOW:

8 ☐ **HIV test results and related treatment** ☐ **Sexually transmitted diseases** ☐ **Genetic Testing**
☐ **Substance Use Disorder (SUD) treatment and/or referral ***

*** If authorizing the release of *SUD treatment and/or referral information*, please specify the information to be released (*Check all that apply*):**

☐ SUD assessments ☐ Aftercare plans ☐ Discharge summary including **SUD** information
☐ Treatment progress ☐ Treatment outcome ☐ SUD screen results
☐ SUD Medications ☐ Lab results related to SUD ☐ Other_____
☐ Compliance/non-compliance with recommended treatment plans, SUD screen results

9 **5. RELEASE VIA**: ☐ US MAIL ☐ FAX ☐ SECURE E-MAIL_____ ☐ PICK UP

6. EXPIRATION: This authorization expires on _____ *(insert date, time period or event)*. Unless otherwise designated, this authorization will expire at midnight one year from the date of my signature below.

10 **7. PURPOSE OF DISCLOSURE:** *(Check all that apply.)* ☐ Continuing care ☐ Insurance eligibility/payment of claims
☐ Obtain collateral information ☐ Personal reasons ☐ Verify compliance with treatment ☐ Other: _____
(Specify purpose)

8.. YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I authorize the release of copies of the health information described above. I understand that I may revoke this authorization; I must do so in writing and present my written revocation (**HIM-056 Cancellation of Authorization)** to the Health Information Department. However, 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 that I have the right to inspect and/or receive a copy of certain health records as provided under Wisconsin Administrative Code §§ DHS 92.05 and 92.06. **I understand that I may be charged a fee for copying, postage and preparation of records associated with fulfilling 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 disclosing the information to a third party. **Redisclosure notice:** 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. This authorization will be effective for health records generated during the time frame specified above, up to and including the date of expiration of the authorization. By signing this Authorization for Disclosure of Protected Health Information, I am authorizing the release of all records applicable to this request that are maintained as part of Rogers' health record regarding me. **Photocopy/facsimile copy is as valid as the original document**.

9. SIGNATURE OF PATIENT: 11 **DATE/TIME:** 12

SIGNATURE OF LEGAL REPRESENTATIVE: 13 **DATE/TIME:** 14

If signed by a Legal Representative, complete the following:
15 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

TO BE COMPLETED BY ROGERS

16 The requested information was: ☐ US MAIL ☐ FAX ☐ SECURE E-MAIL ☐ PICK UP _____ *(Insert date)* by _____
(Name of Rogers's staff processing request)