AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information	**NAME** ____Office Use Only MRN____________________ Date of Birth:______________________________ Day phone____
Health Care Provider or Clinic or Hospital **who** has the information you want released?	**NAME/ORGANIZATION** ____Phone______________________ Address ____Fax________________________ City ____State__________Zip_______________
Where do you want the information to be sent?	**NAME/ORGANIZATION** _________________________________Attn: __________________________ Address ____ Phone: ______________________ City ____State__________Zip____________ Fax Number **(USED FOR URGENT PATIENT CARE ONLY)**________________________________
Why is it needed?	___Continuing Care ___ Workers' Compensation ___ School ___Personal use * ___ Insurance Application* Insurance Payment/Claim* ___ Legal* ___Other ______________________
What are the approximate dates of information you want released? **What** do you want released? Choose **Routine** for items a health care provider typically needs, or select individual records.	**Service Dates Between** ______________________ to_______________________ **Send CHECKED Records Only** ___ Discharge Summary ___Diagnostic Test Results ___ Consultations ___ Radiology Reports ___History and Physical Exams ___ Pathology Reports ___ Psychological Testing ___ Laboratory Reports ___Operative/Procedure Reports ___Progress/Provider Notes ___ HIV/Aids Testing ___ Emergency Reports ___Rehab Reports (PT/OT/SP) ___ Chemical Dependency/Substance Abuse Reports ___ Form Completion ___ Other (specify content and dates) ____ ___ Radiology Films/MRI ___ Billing Records ___ Pathology Slides (are sent directly to the facility listed in Step 3) **OR Send ALL Routine Records** ___Notes, History and Physical, Discharge Summary, Emergency Room, Lab, Radiology, Procedures, Test Results and Consultations **All information regarding alcohol and/or drug abuse or behavioral health will be released unless you restrict by <u>initialing</u>** _______ **Do NOT** release alcohol and/or drug abuse information ________**Do NOT** release behavioral health information
When is it needed?	**Date** the information is needed? _____/_____/______**Or Date of the appointment?** _____/_____/______ To check on the status of your copies, please call 715-939-1737
How do you want the information?	**Release Method / Format requested:** For Copies: ___Paper or ___ Thumb Drive or ___ Fax (for patient care only) ___ Pick Up (Photo ID is required at pick up time) ___Verbal (no copies) For Films/MRI: ____CD/DVD

- This authorization lasts for one year after the date you sign it unless you enter a different expiration date here:________________.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it.
- I understand that Spooner Health may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- I understand, upon request, I will receive a copy of this form after I have signed it.
- I understand that in compliance with WI Administrative Code HHS117, Federal Rule 45 CFR 164.524; Charges may apply. I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.*
- I understand a photocopy or fax of this form is the same as the original.

Patient Signature and Date are required to release records. If an Authorized Person is signing you must include legal documentation.	______________________________ Patient Signature __________________________ Date	______________________________ Signature of Authorized Person ____Parent of Minor ____Court-appointed guardian/conservator Include legal documentation Date ______________________

Mail To: Spooner Health Phone: 715-939-1737
1280 Chandler Drive Fax: 715-939-1559
Spooner, WI 54801-2202

OFFICE USE ONLY: Records Released: ____ Yes ____ No
Released By: ______________________________
Release Date: ______________________________