Health Information Management
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Internal Use Only | MRN
Completed by _____ Date _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Information	First Name Middle Initial Last Name			Medical Record # (if known)
	Date of Birth	Phone Number		
	Street Address	City	State	Zip Code
Records to be Released From	Name/Facility			
	Address City State Zip			
	Phone Fax			
Records to be Released To	Name/Facility			
	Address City State Zip			
	Phone Fax ☐ May schedule and cancel appointments on my behalf			
Information to be sent *(for continued medical care/transfer BMC will release the last 2 yrs. of information unless otherwise indicated)*	I want my records related to:			
	I want my records for these dates of service:			
	I only want the document(s) below for these dates of service: □ History & Physical □ EKGs □ Laboratory Reports □ Progress Notes □ Emergency Records □ Specialty Consults □ Immunizations □ Pathology Reports □ Radiology Reports □ Discharge Summary □ Clinic Notes □ Operative Reports □ Radiology Images □ Therapy Notes □ Billing Records □ Other_____ *All information regarding alcohol and/or drug abuse, behavior health, or HIV/AIDS will be released* ***unless you restrict by initialing:*** _____ Substance Abuse (Drugs and/or Alcohol) _____ Mental/Behavioral Health _____ HIV/AIDS related information			
Purpose for Release	□ Personal Use □ Insurance Eligibility/Benefits □ Other:_____ □ Legal Investigation □ Disability Determination □ Continued Medical Care □ Transferring Care			
Release Method	Paper □ Mail □ Fax -> Number _____ □ Pick up -> Date _____ □ Verbal exchange of information □ CD □ View my record □ Secure email *(recommended method)* Email address _____			
Authorization and Revocation	• A photocopy of this authorization is as valid as the original. • This authorization will be valid for 1 year from the date of signature, unless a date is specified. _____ • I may inspect or receive a copy of the information to be used or disclosed. • I understand the information I authorize a person/entity to receive may be re-disclosed and no longer protected by federal/state privacy regulations. • I understand this authorization is voluntary and I may refuse to sign. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment. • I understand I may revoke this authorization at any time by contacting the Health Information Management department in writing, except to the extent that **a)** records have been released or **b)** if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. • There may be fees associated with copying records (based on Wisconsin statutes).			

Patient / Legal Guardian Signature Authority to Sign Date

Record Definition: The record(s) defined for release include record(s) generated at Burnett Medical Center. Multiple Releases of Information: A patient may request multiple releases of information stated on the Authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's signature. A new Authorization is necessary for release of information for care provided after the date of the patient's signature, unless the Authorization specifically states that specific records generated in the future may be released, for example "future records of a specific test/visit". The patient/representative must contact us regarding these future releases. NOTE: To recipient of information: This information has been disclosed to you from records whose confidentiality is protected by state and federal law. Unless the records of your program are also subject to these laws, you may not make any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. HIV Test Results: HIV test results may be disclosed without the test subject's permission in certain circumstances. A list of such circumstances is available to the test subject upon request to Burnett Medical Center.