

Authorization for Use and Disclosure of Protected Health Information

Patient Information	Name: _____ Previous Name(s): _____ Date of Birth: _____ Day Phone: _____ Email: _____
What Healthcare Provider, Clinic or Hospital who has the information you want released?	Name/Organization: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip Code: _____ Fax/Email: _____
Where do you want the information to be sent?	Name/Organization: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip Code: _____ Fax/Email: _____
Why is it needed?	☐ Continuing care ☐ Insurance application ☐ Workers' Compensation ☐ School ☐ Legal ☐ Personal Use ☐ Other: _____
What are the approximate dates of information you want released?	Service Dates Between _____ to _____
What information do you want released?	Select Records to be Disclosed: ☐ Recent Wellness visit, Health Maintenance records (colonoscopy, bone density, pap, mammogram), most recent two years of lab results. ☐ History and physical exams ☐ Procedure reports ☐ Office visit notes ☐ Lab/pathology reports ☐ HIV/AIDS/STD's testing ☐ Immunization history ☐ Behavioral Health notes ☐ Chemical Dependence/Substance Abuse Reports ☐ Other: _____ Information regarding alcohol and/or drug abuse or behavioral health will be release if requested unless you restrict by initialing: _____ Do not release alcohol and/or drug abuse information

	_____ Do not release behavioral health information _____ Do not release HIV/AIDS/STD's Testing Information
How do you want the information?	Release Method/Format Requested: For copies: ☐ MyAthena ☐ Fax: _____ ☐ Printed ☐ Other: _____
❖ This authorization is effective for one year from the date signed, or on occurrence of the following event (specify): _____ ❖ I understand that I may revoke this authorization at any time by notifying the providing organization in writing at any time, except to the extent that the authorization was acted upon prior to revocation. ❖ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. ❖ I understand that St. Gianna Clinic may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization. ❖ I understand that fees may apply to process my medical records request. I understand that in compliance with WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records. There is no charge for records requested by and released to other healthcare organizations. ❖ The information disclosed is protected by Federal confidentiality rules (42 CFR Part 2), and is intended only for the confidential use of the requester. The Federal rules strictly prohibit anyone from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder, unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.	
Patient Signature and Date are required to release records. If an Authorized Person is signing you must include legal documentation .	Patient Signature: _____ Date: _____ Authorized Person Signature: _____ Date: _____ ☐ Parent of Minor ☐ Court-appointed guardian/conservator <i>(Include legal documentation)</i>