PREVEA health

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) PATIENT INFORMATION:

Name _____ Address _____ City _____ State _____ Zip _____

Date of Birth _____ Daytime Phone _____ Previous Name(s) _____

2) AUTHORIZES:

Name of Health Care Provider/Plan/Other _____

Address _____ Fax # of Health Care Provider _____

3) TO DISCLOSE TO: ☐ Self, Delivery Options: ☐ Pick up ☐ Mail to address above ☐ View on-site ☐ Electronic Format

☐ E-mail to: _____

If the e-email address is shared with another person or the e-mail password is known to others, consider other methods of delivery. HSHS will automatically send e-mail through encrypted/secured means unless otherwise directed. Unencrypted email poses some level of risk, e.g., a third party could see the information without consent. HSHS is not responsible for unauthorized access to unencrypted email containing confidential information or any risk (e.g., virus) potentially introduced to the computer/device utilized when receiving/viewing confidential information in unencrypted electronic format or e-mail. By selecting the unencrypted e-mail option I acknowledge the risks have been communicated and I accept these risks. ☐ Unencrypted Email

☐ To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

Send To: ☐ _____

Name of Health Care Provider/Plan/Other

Address _____ Fax # of Health Care Provider _____

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ to _____ If left blank, only information from the past two (2) years will be disclosed. (Month/Year) (Month/Year) Note: Future dates will not be honored.

5) INFORMATION TO BE DISCLOSED:

☐ Abstract of record/Pertinent records ☐ History & physical ☐ Discharge summary
☐ Emergency Department report ☐ Consultation reports ☐ Operative reports
☐ Radiology/Imaging reports ☐ Laboratory/Pathology ☐ EKG
☐ Radiology/Imaging films/CD ☐ Progress notes _____ ☐Billing records _____
Specific records and/or information as follows: _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):
☐Alcohol/Drug Abuse ☐HIV Test Results ☐Mental Health/Developmental Disabilities

6) EXPIRATION: This Authorization is good until the following date/event: _____
Or if this item is left blank, the authorization will expire in (1) year from the date signed.

7) PURPOSE (check all that apply – copy fees may apply): ☐ Patient Request ☐ Continuing Care
☐ Legal Investigation/Action ☐ Insurance Eligibility/Benefits ☐ Other: _____

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that I have the following rights: to inspect and/or receive a copy of the health information; to have information be used and/or disclosed by this Authorization; if I agree to sign this Authorization, I will be provided with a copy of it; I may be charged a fee for record copies; I am under no obligation to sign this form and treatment, payment, enrollment or eligibility for benefits may not be based upon my decision to sign this Authorization; Authorization may be needed to release information to payers for certain mental health services, AODA services and/or HIV testing, however, I can refuse to sign this Authorization form for such purposes but I may be responsible for paying the entire bill for such services; I may revoke this Authorization at any time by notifying the authorizing provider's health information department, as listed above, in writing and will not be effective as to uses and/or disclosures already made in reliance upon this Authorization, needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage, or to submit a claim to third party payers as provided in this Authorization after having provided treatment in reliance upon this Authorization; the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient and may no longer be protected by applicable federal privacy law, Wisconsin or Illinois Law. *Federal Regulation (42 CRF, Part 2)/AODA prohibits any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by regulations. However, I understand that any disclosure of information carries the potential for unauthorized re-disclosure and the information may not be protected by Federal privacy standards. I understand that if there is not an existing treatment provider relationship with the party to whom information is being sent, a general designation may be used. I understand that I may request a list of entities to which my information has been disclosed from the "Send To" entity listed above*.

9) SIGNATURE OF PATIENT: _____ Date: _____ and/or
SIGNATURE OF LEGAL REPRESENTATIVE: _____ Date: _____
WITNESS SIGNATURE (AODA/Mental Health Only): _____ Date: _____
If signed by a person other than the patient, complete the following:
1) Individual is: ☐ a minor (AODA exception) ☐ legally incompetent or incapacitated ☐ deceased
2) Legal authority: ☐ parent* ☐ legal guardian ☐ activated POA for Health Care ☐ next of kin/executor of deceased
*By signing above, I hereby declare that I have not been denied physical placement of this child.

OFFICE USE ONLY: Signature/ID verified: ☐ Yes ☐ No Date/Time Released: _____ Completed by: _____ Medical Record Number: _____

Original: Medical Record Copy: Patient A photocopy of this authorization will have the same force and effect as the original