AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

STOCKBRIDGE-MUNSEE HEALTH AND WELLNESS CENTER

W12802 CTY ROAD A / PO BOX 86 ✦ BOWLER, WI 54416 ✦ Phone (715) 793-4144

Patient's Legal Name_____________________________________ Medical Record NO:______________

Previous Names/Nicknames:______________________________ Date of Birth_____/______/_____

I authorize the use or disclosure of the above named individual's health information as described below.

INFORMATION RELEASED FROM: The following organization authorized to make the disclosure is:

Name______________________________________

Street Address______________________________

City/State/Zip______________________________

Phone___________________Fax________________

INFORMATION RELEASED TO: This information may be disclosed to and used by the following organization:

Name______________________________________

Street Address______________________________

City/State/Zip______________________________

Phone___________________Fax________________

TYPE OF INFORMATION TO BE DISCLOSED: (Check all applicable categories):

_____Immunizations _____X-Ray Reports/Films (circle choice) _____Doctor's Orders & Progress Notes

_____Lab Reports _____Pregnancy Records _____Chiropractic/Physical Therapy Notes (Circle Choice)

_____Dental _____EKG Reports _____Other (Please Specify)__________________________

_____Entire Record (Specify Time Frame)______________________________

I understand that the disclosure of my health records will not include disclosure of HIV test results or mental health and/or drug abuse records unless specifically authorized.

_____Mental Health _____HIV (AIDS) _____Drug Abuse _____Alcoholism

PURPOSE FOR DISCLOSURE:

_____Disability Determination _____At the request of the individual

_____Legal Investigation/Court case _____Other (Please Specify)_______________________________________

NOTICE TO PATIENT

I understand that I have a right to revoke this Authorization at any time. I understand that if I revoke this Authorization I must do so in writing and present a written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this Authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy

Unless otherwise revoked, this Authorization will expire on the following date, event, or condition:________________________ ______________________ If I fail to specify an expiration date, event, or condition, this Authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I have read statements about charges and obtaining copies of medical records printed on the reverse side of this form. I can refuse to sign this Authorization. I understand that signing this form is not a condition for receiving treatment, payment for services, enrollment or eligibility for benefits. I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have a question about disclosure of my health information, I can contact the Privacy Officer.

(A FAX copy/photocopy of this authorization shall be considered as valid as the original.)

____ ____________________________________

Signature of Patient or Legal Representative Date Signature of Witness

If Signed by Legal Representative, Relationship to Patient:_____________________________________

☐ Patient Hand Carried ☐ Mailed ☐ FAX Date_________________ Initials of person releasing:__________

Patient Phone # __________________________________

CHARGES

There is a charge for copying Health records. Please contact the Medical Records Department for general information about fees. Fees are **PAYABLE IN ADVANCE** to the Stockbridge-Munsee Health and Wellness Center Billing Department.

FEE CHARGES: No fee will be charged for requests for immunization records. There will be a fee of $5.00 minimal charge per patient request for records. A fee of $0.50 per records face page or $1.00 per double sided record page will be charged for the first 50 record pages. A fee of $0.25 per records page or $0.50 per double-sided records page will be charged for any and all pages requested after the first 50 pages. A fee of $10.00 will be charged for each X-ray film copy request. These charges are set in accordance with the SMHWC Policy #202MERE0001.

LIMITATIONS

Information released under this Authorization is released for the purposes stated herein. The Stockbridge-Munsee Health and Wellness Center is not responsible for re-disclosure or use by any other person or organization.

For information relating to treatment for alcohol or drug abuse, this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.