Prairie Ridge HEALTH

Inspired by you

1515 Park Avenue • Columbus, WI 53925
Medical Records (920) 623-1528 • Fax (920) 623-1581
ER (920) 623-1255 • ER Fax (920) 623-6441

For PRH use only:

Patient's MRN: _____

Account #: _____

Request Completed/Fulfilled by:

_____

Date: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

_____ _____ _____

Name of Patient/Previous Names | Birth Date | Phone Number

_____ _____

Street Address | City, State, Zip Code

AUTHORIZES:

_____

_____

_____

TO RELEASE PROTECTED HEALTH INFORMATION TO:

_____

Name of Health Care Provider/Plan/Individual/Other

_____

Street Address

_____

City, State, Zip Code

INFORMATION TO BE RELEASED FOR THE FOLLOWING DATES:

_____

☐ Medical History, Examination, Reports
☐ Treatment or Tests
☐ X-ray Reports
☐ Prescriptions
☐ Other (Specify):_____
☐ Surgical Reports
☐ Hospital Records, including reports
☐ Allergy Records
☐ Consultations
☐ Immunizations
☐ Laboratory Reports
☐ View Only Access

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

☐ Continuing Care
☐ Insurance Eligibility/Benefits
☐ Other (Specify): _____
☐ Personal
☐ Legal Investigation or Action
☐ Changing Physicians

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Mental Health ☐ Developmental Disabilities ☐ Alcoholism
☐ HIV/AIDS ☐ Sexually Transmitted Disease ☐ Drug Abuse
☐ Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Medical Records Department.
Right to Receive Copy of This Authorization – I agree that if I sign this authorization, which I am not required to do, I will be provided with a signed copy of the form at my request.
Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
Right to Withdraw This Authorization – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw or to receive a copy of my withdrawal, I may contact the Medical Records Department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.
HIV Test Results – I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I also understand that there may be a copy fee(s) associated with my request.

SIGNATURE PATIENT/LEGAL REP: _____
(if signed by other than the patient, state relationship and authority to do so.)

DATE: _____ **WITNESS:** _____

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled Deceased

Legal Authority: Custodial Parent, Legal Guardian, Executor or Estate of Deceased, Power of Attorney for Healthcare, Authorized Legal Representative