

REQUEST # _____



For Office Use:	
Date Request Received: _____	Initials: _____
<input type="checkbox"/> Picked Up	<input type="checkbox"/> Mailed <input type="checkbox"/> Other _____
Date and Time Released: _____	Initials: _____

Bay Area Medical Center Authorization to Inspect or Release Protected Health Information

1. _____

Name of Patient	Date of Birth	Telephone Number
_____	_____	_____
Street Address	City	State Zip Code
_____	_____	_____

2. I authorize Bay Area Medical Center Employed Physician Clinic – Indicate Physician Name(s) _____

To (check one) Release to: Obtain from:

Check one: Self Other – Name/Address: _____

Media Release see below

3. Information from my health care record for the following date(s): From _____ to _____

4. Specific information to be disclosed includes: All pertinent reports (History & Physical, Discharge Summary, Operative Report, Consultation)

<input type="checkbox"/> FIN/Registration	<input type="checkbox"/> ER Report	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Operative Report
<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Lab	<input type="checkbox"/> Consultation	<input type="checkbox"/> X-Ray	<input type="checkbox"/> EKG
<input type="checkbox"/> Orders	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> HIV Test Results	
<input type="checkbox"/> Other _____				

Entire Record – Please check if release of “entire record” may include the following: Sexually Transmitted Disease

HIV Test Results, AIDS or AIDS-related Disease Mental Health Counseling Records

Alcohol Abuse or Test Results Drug Abuse or Test Results

Media Release Only – I understand that from time to time the media (such as newspaper, radio stations, television or others) ask about a patient’s hospitalization or condition. To assist BAMC in case of questions, please check one of the following:

I agree that the following information may be released if requested by the news media (Cross out any you do not wish to release):
Name, Address, Age, Sex, General Statement of Condition, Description of Injuries

Release of information, such as description of injuries in accordance with BAMC policies.

I do not want any information released to the media or others about my condition.

5. Purpose or Need for Disclosure of Information: (Check any that apply) Continuing Care Patient Request Legal

Employer Use Insurance Media Release Other _____

Re-disclosure notice: I understand that the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient, and/or no longer protected by Federal Privacy standards.

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 a right to inspect or receive a copy (with possible fee) of the health information I have authorized to be used or disclosed by this form. I understand that I am not entitled to inspect or obtain a copy of any psychotherapy notes, any information Bay Area Medical Center may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, or any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 u.s.c. sec. 263a) and certain other records. I understand that Bay Area Medical Center’s Privacy Officer or designee will inform me in writing if my request is accepted or denied within 30 days if protected health information is on site or 60 days if protected health information is off site, of receipt of this request. I understand that one 30 day extension is permitted and the Privacy Officer or designee will provide me with a written statement if an extension is required, the reason for the delay, the date by which my request will be processed. If my request to inspect the record is accepted, I understand that I will need to arrange with Bay Area Medical Center’s Privacy Officer or designee a time and place for me to inspect the record during business hours, or Bay Area Medical Center’s Privacy Officer or designee will mail me a copy of the medical record. I understand that Bay Area Medical Center may choose to provide a summary or explanation of the requested protected health information. I understand that Bay Area Medical Center may charge a reasonable, cost-based fee for copying, postage, and preparation. I understand that any fee necessary to fulfill my request will be included in the letter from Bay Area Medical Center and must be paid in full prior to my receipt or inspection of the medical record. **Right to Receive a Copy of this Authorization** – I understand that if I agree to sign this authorization, I will be provided a copy of it. **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form. Treatment, payment, enrollment or eligibility for benefits may not be based upon my decision to sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services.) **Right to Revoke this Authorization** – I understand that I may revoke this authorization by requesting, completing and returning a Revocation Form to Bay Area Medical Center’s Privacy Officer. **HIV Test Results** – HIV test results are protected under Wisconsin State Statute 252.15 and may not be disclosed without written informed consent/authorization, except to persons or organizations that have been given access by state law. A list of persons/organizations is available upon request.

I understand that I may be charged a reasonable, cost-based fee for copying, postage, and preparation. Bay Area Medical Center will charge you:

\$ _____ per page to copy these records \$ _____ for a summary or explanation of the requested records \$ _____ for mailing/postage

6. **Expiration Date:** This authorization is good until (indicate date/event) _____

Authorization will automatically expire one year after the date signed unless otherwise indicated above.

7. **Signature of Patient or Legal Representative*** _____

If signed by Legal Representative – State Relationship to patient _____

8. **Date** _____

9. **Signature of Witness** _____

10. **Date** _____

A photocopy of this authorization will have the same force and effect as the original.

* Legal Representative means the parent, guardian, legal custodian of a minor patient; the guardian of a patient adjudged incompetent; person authorized in writing by the patient; a health care agent designated under Chapter 155 if properly activated; a temporary guardian appointed by a court to consent to release records; the spouse or personal representative of the deceased patient, or if no spouse survives a deceased patient (and no personal representative), an adult member of the deceased patient’s immediate family. A copy of the appointment as personal representative, guardian, or health care agent is required.