PRINT SAVE AS EMAIL RESET

Children's Hospital of Wisconsin

Authorization for the Use or Disclosure of Protected Health Information (Verbal Exchange and/or Medical Records)

PATIENT LABEL OR

MRN:_____

1. PATIENT INFORMATION:

_____ / / _____

Last Name | MI | First | Date of Birth

_____

Address | City | State | Zip

(_____)_____ (_____)_____ _____

Cell Phone | Home Phone | Email

2. I AUTHORIZE INFORMATION TO BE RELEASED FROM:

- ☐ Children's Hospital of Wisconsin
- ☐ Main Campus Clinics (specify): _____
- ☐ Primary Care: Site: _____
- ☐ Child and Family Counseling: Site: _____
- ☐ Other CHW Clinic (specify): _____
- ☐ Surgicenter
- ☐ Fox Valley Clinics
- ☐ Other: _____

3. INFORMATION WILL BE GIVEN TO/EXCHANGED WITH:

_____
Name/Facility

_____
Address | City | Zip

(_____) _____
Phone | Fax

4. REASON INFORMATION IS NEEDED: (Copy fees may apply)

☐ Ongoing Medical Care ☐ Personal Use ☐ Legal Investigation ☐ Referral ☐ Insurance Eligibility/Benefits
☐ School Use ☐ Other: _____

5. VERBAL EXCHANGE OF INFORMATION ☐ CHECK THIS BOX TO ALLOW VERBAL COMMUNICATIONS AMONG THOSE INDICATED ABOVE

- **NOTE- If only allowing verbal communication and NO medical records should be sent, skip to number 7**

6. MEDICAL RECORD INFORMATION TO BE RELEASED: (See back for important tips):

☐ Clinic Records (specify):_____
☐ Inpatient Hospital Records from dates of service: From: _____ To: _____
☐ Only these specified documents: _____
☐ Consults ☐ Discharge Summary ☐ Diagnostic ☐ ER Visit ☐ History and Physical ☐ Lab
☐ Operative Report ☐ Pathology Report ☐ Radiology Report ☐ Other: _____
☐ Radiology Films: _____
☐ Other: _____

7. I DO NOT WANT THE FOLLOWING INFORMATION RELEASED OR DISCUSSED: (as defined by applicable state and federal laws)

☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV Test Results ☐ Genetics
☐ Alcohol/Drug Treatment ☐ Other (Please List):

8. HOW INFORMATION WILL BE RELEASED:

Check One: ☐ Verbal ☐ Paper ☐ MyChart:

- **IF PAPER OR ELECTRONIC, RELEASED BY:** ☐ MEDICAL RECORDS ☐ OTHER (specify): _____

Release By: ☐ US Mail ☐ Pick Up ☐ Fax (only to healthcare organizations):(_____) _____

Person allowed to pick up records if other then the person listed above in Number 3

_____ _____
Name | Relationship

9. EXPIRATION DATE:

This Authorization is valid until the following date/event: (not to exceed 3 years): _____
If no date is listed, this authorization is good for three (3) years from the date signed below.
This includes records that are created after the date this authorization is signed, up until the expiration date.

10. PLEASE SEE BACK SIDE OF THIS FORM BEFORE SIGNING FOR MORE INFORMATION.

I have read, understand and agree to the information above and on the back of this form, I authorize the release of my/the child's Patient Health Information.

_____ _____
Patient, Parent or Legal Guardian Signature | Date

☐ Parent - I declare that I am the above named minor child's guardian.
☐ Self ☐ Legal Guardian (must provide paperwork) ☐ Other (please list): _____

11. STAFF: _____ Date: _____

Please see back side of this form to find out when a witness is needed to sign the form.

FINAL RELEASE OF RECORDS IS AT DISCRETION OF THE MEDICAL RECORD DEPARTMENT.

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ADDITIONAL INFORMATION REGARDING THE RELEASE OF MEDICAL RECORD INFORMATION FROM CHILDREN'S HEALTH SYSTEM

PLEASE READ THE FOLLOWING BEFORE VOLUNTARILY SIGNING THE FRONT OF THIS RELEASE FORM.
All of Children's Hospital and Health System (CHHS) entities respect the patient's right to privacy of confidential medical information. I have had an opportunity to review and understand the content of both sides of this form.

Disclosure (release) of information.
Federal and Wisconsin Confidentiality laws protect this information. The laws forbid this information to be re-released unless:

- The person whose information it is gives written consent, or
- Otherwise permitted by law

I understand that the person receiving this information (recipient) might re-release this information. If this happens, the information may not be protected by the state and Federal laws anymore.

RIGHT TO REFUSE TO SIGN
I understand that this authorization is voluntary and that I can refuse to sign it. Treatment, payment or enrollment in a health care plan will not be affected if you refuse to sign.

REVOCATION
I understand that I have the right to revoke this authorization at anytime. I must do so by submitting my revocation in writing to the Medical Record Department. My revocation will not apply to confidential information that has already been released in response to this or another Disclosure form.

LIABILITY
All CHHS entities, employees, officers and attending physicians are released from legal responsibility or liability for the release of information as indicated on this form.

VALIDITY OF FORMS
A photocopy or facsimile (fax) of this Disclosure Form is as valid as the original.

ORIGINAL PATHOLOGY SLIDES
In certain circumstances, pathology slides/specimens are loaned out to other Health Care professionals. These slides/specimens must also be returned within 30 days of send out by the laboratory department.

STAFF SIGNATURE: A staff signature is required on form if:

- The parent or legal guardian is unable to sign, or can only make a mark.
- A minor with legal rights requests the information.
- If staff is assisting the patient or family in the completion of the form.
- Other times when it is decided that a witness is needed.

IMPORTANT TIPS: For each numbered area on the form:

#1- Print and be sure to include the date of birth of the patient.
#2- Be specific about which site you want records to be released from.
#3- If releasing to a doctor, include the hospital or facility.
#4- If military request, place the reason under Other.
#5- Fill in if authorizing verbal communications.
#6- Be specific regarding the medical records to be released.
#7- If you do not want specific information released, you must check a box to not include these.
#8- Choose how the information is to be released.
#9- This authorization will be valid for three years, unless another date is indicated.
#10- Be sure to sign and date the form.

- If you need assistance in filling out the form, please contact the Medical Record Department at 414-266-2301. You can also fax the form to 414-266-6316 or email it to MedicalRecords@chw.org
- Be sure the form is filled out completely to ensure prompt processing.