RELEASE OF INFORMATION and AUTHORIZATION TO DISCLOSE

MRN: (Office Use Only) _____

Medical Records related to care provided in a hospital or surgery center, such as the Emergency Department or Anesthesia services at a facility, are maintained by and can be obtained from the facility where the service was provided. ***Many BayCare Clinic records can be requested and received at no charge via the myBayCare patient portal: https://my.baycare.net/BaycareClinicsMyChart/***

Please complete sections 1-8. If you have questions about this form, please call 920-544-5414.

1. _____

Patient Name | Address | City | State | Zip

_____ _____ _____

Telephone Number | Date of Birth | Last 4 of SSN

2. Authorizes (Select 1)**:**

☐ BayCare Clinic (Specify **ALL** Providers/Departments or List individual Providers/Departments)_____

☐ Other Provider/Office/Facility_____Address: _____

City, State, Zip Code_____Phone: _____Fax: _____

3. To Disclose/Send Records To (Select 1):

☐ BayCare Clinic (Specify Providers/Departments)_____

☐ Other***: (FILL IN)*** Name: _____Address: _____

City, State, Zip Code: _____Phone: _____Fax: _____

Email address: _____

4. INFORMATION TO DISCLOSE (check all applicable)

Dates: From_____to_____

☐ Office Notes ☐ X-Ray Reports

☐ Lab ☐ Billing Records

☐ BayCare Radiology Images

(Specify Images for CD):_____

☐ Form _____

☐ Other_____

5. DELIVERY METHOD (may select more than one)

☐ Verbal

☐ BayCare patient portal

Fee may apply:

☐ Mail

☐ Fax to_____

☐ Pickup Records

☐ Digital (CD)

☐ Encrypted Email (must provide address in #3 above)

6. PURPOSE FOR DISCLOSURE

☐ Legal

☐ Insurance

☐ Personal

☐ Continuing Care

☐ Worker's Comp

☐ Other: _____
(e.g. FMLA, disability, employment)

I understand that the information to be disclosed may include information regarding mental health/developmental disabilities, substance use disorder and HIV status. We will release this information unless you indicate which information should be excluded below:

☐ Substance use disorder ☐ HIV status ☐ Mental health/developmental disabilities

7. This authorization is valid until the **earlier** of one year from the date of signature below or the following date: _____

I understand that: I can revoke this authorization in writing, which will be effective upon receipt by the BayCare Clinic Release of Information Department. Signing this form authorizes the release of information to the entities above; this means that should that entity re-disclose my protected health information, the information may no longer be protected within the guidelines of federal privacy standards. I have a right, upon written request, to inspect the materials disclosed and that this inspection is at no cost to me and will be in the presence of a BayCare Clinic employee. I understand that I can receive a copy of the materials disclosed as required by law and that I am responsible for all associated copying fees that are charged in accordance with Wisconsin Statutes. Information relating to my treatment may be released upon my agreement or as otherwise specified by 42 CFR, 45 CFR 164.508 and Wisconsin State Statutes 51.30, 146.025 and 146.81. My signature on this form is not required for me to receive treatment. I have read and understand the contents of this form and may request a copy of this form. I understand that if I elect to type my name below, it has the same legal effect as my handwritten signature.

_____ _____ _____

8. Signature of Patient or Representative | Date | Printed Name

If signed by a person other than the patient, complete the following:

- Patient is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
- I am the patient's: ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care ☐ foster parent