Black River Health

MRN_____

FIN_____

Release of Information Authorization

1. Patient Information	Name:		Date of Birth:
	Previous Name:		
	Address:	City:	
	Phone #:	State:	Zip:
2. Healthcare Provider of the Facility who has the information you want released	☐ Krohn Clinic ☐ Black River Memorial Hospital ☐ Black River Healthcare Clinic ☐ BRH Behavioral Health ☐ **Alcohol Treatment ☐ **HIV Results ☐ All ☐ Other: _____		
	Address:	City:	
	Attention:	State:	Zip:
	Phone #:	Fax #:	
3. Where you want the information to be sent	☐ Krohn Clinic ☐ Black River Memorial Hospital ☐ Black River Healthcare Clinic		
	Name/Organization:		
	Attention:	Fax #:	
	Address:	City:	
	Phone #:	State:	Zip:
4. Why the information is needed	☐ Continuing Care ☐ Worker's Compensation ☐ School ☐ Per Patient Request ☐ Insurance Purposes ☐ Legal ☐ Form Completion (FMLA/Disability, etc.) ☐ Other: _____		
5. What information you want released	Clearly identify records to be released by completing <u>at least one</u> of the section A or B. **If not completed, 2 years' worth of information will be provided.		
	<u>A. Service Dates:</u> Between _____ to _____ <u>B. Specific Diagnosis or Provider:</u> _____		
	<u>C. Specific types of records not identified in A or B</u> ☐ Billing Records ☐ Photographs ☐ Radiology Images ☐ Other:_____		
6. When the information is needed by	Date information is needed: _____ Date of the appointment: _____		
7. How would you like this information	<u>Release Method/Format Requested</u>: Information supplied electronically is in PDF format ☐ Mailed ☐ Faxed ☐ Pick Up ☐ CD Other: _____		
8. Expiration	This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional period of time as indicated here: _____		

Black River Health

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FIN_____

RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION: I have a right to receive a copy of this authorization after I sign it.

RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION: I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment.

RIGHT TO REVOKE THIS AUTHORIZATION: I have the right to revoke this authorization at any time by providing a written statement of revocation to Black River Health's (BRH) Health Information Management (HIM) Department. My revocation will not be effective until the BRH HIM Department receives it and will not be effective regarding the uses and/or disclosures of my protected health information made prior to receipt of my revocation statement. 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.

RE-DISCLOSURE: If I authorize release of my protected health information to an individual or agency not covered by federal or state laws that prohibit re-disclosure, my protected health information may not remain confidential.

RIGHT TO INSPECT OR COPY OF INFORMATION USED OR DISCLOSED: I have the right to inspect or receive a copy of material disclosed by this authorization form. (Reasonable fee may be associated.)

PROHIBITION OF CONDITIONS: Black River Health may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

A photocopy of this authorization shall be considered as valid as the original.

HIPAA Privacy & Security Officer contact information: 715-284-5361.

In accordance with the conditions listed above, I authorize the use and/or disclosure of my protected health information.

☐ By checking this box, I (the patient) am requesting a copy of this authorization ☐ Copy Given to Patient

_____ _____

Patient Signature Date/Time

_____ _____ _____ _____

Signature of Authorized Person Printed Name Date/Time (Relationship)

If you are signing as a parent of the minor patient listed above, you are declaring that your parental rights have not been terminated and you have not been denied physical placement of child.

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Legal Guardian (attach proof of court action) ☐ Next of Kin (Immediate family member of deceased)

BRH USE ONLY

Employee Initiating Form: _____ Date/Time: _____

Medical Records Released by:_____ Date/Time: _____

Route: ☐ Mail ☐ With Patient ☐ Other: ☐ Fax ☐ Copy of this authorization provided

711 W Adams St, Black River Falls, WI 54615 | Phone: 715-284-5361 | Fax: 715-284-7166