BAYCARE CLINIC

RELEASE OF INFORMATION and AUTHORIZATION TO DISCLOSE – WRITTEN RECORDS

PLEASE NOTE: BayCare Clinic maintains records for care provided by a BayCare Clinic provider within the clinic setting. Medical Records related to care provided in a hospital or surgery center such as services rendered in a Radiology Department or Emergency Department or Anesthesia services at a facility are maintained by and can be obtained from, the facility where the service was provided.

1. PATIENT INFORMATION:

Patient Name:_____ Date of Birth:_____/_____/_____ Phone #: (_____)_____

Address:_____ Last 4 of SSN: _____
Street City / State / Zip

2. INFORMATION RELEASED FROM: ☐Provider:_____ ☐Clinic Dept:_____ ☐All BayCare Providers

3. INFORMATION SENT TO:

RECORDS DEPOSITION SERVICE, INC. (248) 357-3330 (248) 357-3337
Name (Self, Other Person, Attorney, Insurance co, etc) Phone # Fax #

PO BOX 5054 SOUTHFIELD MI 48086-5054
Street City State Zip

4. PLEASE CHECK ONE: ☐Mail Records to above address ☐Fax Records ☐Will Pickup Records

5. TYPE OF INFORMATION TO BE DISCLOSED: ☐ Medical Information and/or ☐ Billing Information (*mark one or both boxes*)

All Records maintained by the Provider/Department noted above from (specific dates): _____to _____

Specific Records (Specify consultation, Progress notes, etc.):_____
From : _____ to _____
Date Date

BayCare Clinic Radiology (x-ray) images (specify image) : _____
From : _____ to _____ ***NOTE: Images not taken at BayCare Clinic must be requested from the performing facility***
Date Date

Wisconsin Statutes require specific authorization prior to disclosing certain information.
PLEASE CHECK THE FOLLOWING BOXES TO ALLOW FOR DISCLOSURE OF THE FOLLOWING:

☐Mental Health Records ☐Alcohol/Drug Abuse Treatment ☐Developmental Disability ☐HIV Status

6. PURPOSE OR NEED FOR DISCLOSURE: ☐Legal ☐Insurance Application ☐Personal ☐Continuing Care ■Other: PRE TRIAL DISCOVERY

7. AUTHORIZATION/RIGHTS :

This authorization is valid for one (1) year from date of signature. I understand that I can revoke this authorization in writing, which will be effective upon receipt by any BayCare Clinic Department. I understand that BayCare Clinic may disclose information to additional entities upon receiving verbal or written authorization from me. I understand the completion and signing of this form authorizes the release of information to the entities named 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 understand that 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 under ss.HSS.92.05 and 92.06 and that associated copying fees are charged in accordance with Wisconsin Statutes. I understand that 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. I understand that my signature on this form is not required for me to receive treatment at this time. A copy of this signed document shall be provided to the patient upon request. I have read and adequately considered the contents of this form.

_____ _____
Signature of Patient or Representative Date Printed Name / Relationship of Representative to Patient