SSMHealth.

SSM Health Dean Medical Group
SSM Health Surgery Center
SSM Health Digestive Health Center
SSM Health St. Mary's Hospital – Madison
SSM Health St. Mary's Hospital – Janesville
SSM Health St. Clare Hospital

❑ SCAN ONLY-No additional information needed

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in full. See reverse side for important information)

1.

Name of Patient

Street Address

City, State, Zip code

Date of Birth Phone #

I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization by providing written notice to SSM Health. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. AUTHORIZE:

SSM Health
(Name of Physician/Health Care Facility/Other)

PO Box 259840
(Street Address)

Madison, WI 53725-9840
(City, State, Zip code)

608-294-6294 **OR** 877-469-7593
(Fax)

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:
(If Release is to Self, State Self)

RECORDS DEPOSITION SERVICE, INC.
(Name of Physician/Health Care Facility/Other)

PO BOX 5054
(Street Address)

SOUTHFIELD, MI, 48086-5054
(City, State, Zip code)

248-357-3337
(Fax)

4. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

❑ Continuing Care ❑ Transferring Care (Customary to release last 2 years of information. Release may occur electronically)

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt Date ____/____/____ (MM/DD/YYYY)

❑ Worker's Compensation Research ☑ Other (specify): PRE TRIAL DISCOVERY

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam

❑ Operative Reports ❑ Immunization Records ❑ Lab Reports ❑ Imaging Reports

❑ Medical Images (specify) _____ ❑ Billing Records (specify) _____

☑ Specific information related to: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: ____/____/____ (MM/DD/YYYY) To: ____/____/____ (MM/DD/YYYY)

5a. This authorization includes disclosure of information regarding mental health, alcohol and/or drug abuse, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. FORMAT FOR RECORDS: ❑ MyChart ❑ DVD/CD ❑ Paper ❑ Verbal Disclosure ❑ Fax
❑ Email to: _____

7. EXPIRATION

This authorization will expire on ____/____/____ (MM/DD/YYYY). If I do not indicate a date, this will expire one (1) year from the date of my signature below. A photocopy of this authorization is as valid as the original.

8. SIGNATURE

I understand that this authorization is voluntary. I understand that there may be a charge for copies. I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this Authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____ Patient is: ❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ❑ Parent of MInor ❑ Spouse of Deceased ❑ Health Care Agent _____
❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.