AUTHORIZATION TO VIEW / DISCLOSE HEALTH INFORMATION

Patient Name ______________________ MR Number ______________

Address ______________________ City ____________ State ________ Zip ________

Date of Birth ____________ Social Security # ______________ Phone ______________

I authorize the use or disclosure of the above named patient's Protected Health Information as described below:

FROM:

WHEATON FRANSICAN HEALTHCARE:

Wheaton Franciscan: ☐ St. Joseph Campus ☐ The Wisconsin Heart Hospital Campus

Wheaton Franciscan Healthcare: ☒ Elmbrook Memorial ☐ Franklin ☐ St. Francis ☐ St. Michael

OTHER:

____

____

TO:

Name **RECORDS DEPOSITION SERVICE, INC.**

Address **PO BOX 5054**

City **SOUTHFIELD** State **MI**

Zip **48086 - 5054**

Fax Number **248.357.3337** **P: 248.357.3330**

FOR THE PURPOSE OF: (Check all that apply.)

☐ View Protected Health Information ONLY: Date ____________ Time ____________

☐ Continued Care ☒ Legal ☐ Insurance ☐ At Request of Patient ☐ Other ______________

INFORMATION TO BE VIEWED AND OR DISCLOSED:

Date(s) of Service: ____________ **to** ____________ **or Type:** ______________

☐ Record Abstract ☐ Discharge Summary ☐ History & Physical ☐ Operative Record ☐ Lab Results
☐ X-ray Reports ☐ Emergency Record ☐ HIV/AIDS (including test results) ☐ Substance Abuse Record
☐ Mental Health Treatment Records ☐ Immunization Record
☐ Other ______________________________

I understand that the information in my health record may include information relating to mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that if I refuse to authorize the disclosure of this information, the information may not be released.

I further understand that HIV test results may be disclosed without my permission in certain circumstances and that a list of such circumstances is available to me upon request.

I further understand that I have a right to inspect or receive a copy of any health information used or disclosed. I understand that if I sign this authorization, I will be provided with a copy of this authorization upon request.

In support of your privacy, WFH does not accept your blanket authorization to disclose Protected Health Information of treatment you have not yet received unless the authorization specifically requests release of information of further treatment of the condition treated in the originally requested episode . A new authorization will be required for each new episode of care.

PATIENT LABELS MUST BE PLACED HERE ON ALL PAGES (PARTS) – SIDES OR FOLD-OUT (PANELS) THAT THIS BOX APPEARS ON.

I understand that I have a right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the Health Information Department. I understand that my revocation will not apply to information that has already been released in response to this authorization.

I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected by such laws.

This authorization expires 365 days from the date it is signed by the patient unless otherwise noted ________________.

This authorization is voluntary. Wheaton Franciscan Healthcare will not condition your treatment on this authorization.

____	______________	____________
Signature of Patient or Authorized Representative	Date	Time

(If you are signing as a parent of the minor patient listed above, you are declaring that you have not been denied physical placement and/or parental rights of the child because such placement would endanger the child's physical, mental, or emotional health.)

If signed by other than patient, indicate relationship or authority:

Patient is: ☐ a Minor ☐ Incompetent ☐ Deceased

I am: ☐ Parent ☐ Legal Guardian ☐ Next of Kin of Deceased ☐ Executor of Estate

☐ POA for health care (activated)

____	______________	____________
Signature of Witness	Date	Time

If unable to sign document, give reason ____

NOTE: "This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

OFFICE USE RELEASE LOG

Identification Verified: ___________ (initials) Signature Verified: ___________ (initials) Date: __________ Time: __________

Route of Release: ☐ Fax ☐ Mail ☐ Pick-up ☐ Patient notified of applicable fees

Authorization to View / Disclose Health Information for Hospitals

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