AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

MAIL, FAX OR DROP OFF:

Turville Bay MRI & Radiation Oncology Center
Health Information Management (HIM)
1104 John Nolen Drive
Madison, Wisconsin 53713

Medical Records Phone # 608-259-4426
Imaging Fileroom Phone # 608-259-4393

HIM FAX #: 608-258-7832

PATIENT INFORMATION (please print legibly):

Name of Patient / Previous Names ________ Birth Date (mo/day/yr) ________ *MRN # (HIM office use only)*

Street Address ________ City, State, Zip ________ (Area Code) Phone Number

AUTHORIZES DISCLOSURE BY: *(where is info coming from)*

☐ ***Turville Bay MRI/RO Center*** **OR**

Other *(Specify facility/individual & address below, including phone/fax if known.)*

Name of Health Care Provider/Plan/Other

Clinic / Facility Name

Street Address

City, State, Zip Code

Phone Number ________ Fax Number

AUTHORIZES DISCLOSURE TO: *(where is info going to)*

☐ ***Patient*** **OR** ☐ ***Turville Bay MRI/RO Center*** **OR**

Other *(Specify facility/individual & address below, including phone/fax if known.)*

RECORDS DEPOSITION SERVICE, INC.
Name of Health Care Provider/Plan/Other

Clinic / Facility Name
PO BOX 5054
Street Address
SOUTHFIELD, MI, 48086-5054
City, State, Zip Code
248-357-3330 ________ 248-357-3337
Phone Number ________ Fax Number

- **MRI Patients:** *Please check appropriate box(s):*
  - ☐ MRI ***Report***(s) **ONLY** from date(s) & condition(s): ________
  - ☐ MRI ***Images*** from date(s) & condition(s): ________
- **Radiation Oncology Patients:**
  - ☐ Radiation Oncology Note(s) from date(s) and/or condition(s): ________

The information to be released may include records related to psychiatric, developmental disability, alcohol or drug abuse, HIV test results/AIDS unless specified: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

☐ Continuing Care
☐ Disability Determination
☐ Transfer to New Provider
☐ Patient Request (Personal) (There is a charge for CD)
☐ Insurance/Claim Purposes
☐ Workers Compensation
☐ Legal Purposes
☒ Other: PRE TRIAL DISCOVERY

EXPIRATION DATE: This authorization is good for 2 (two) years from the date signed ***or*** until (date) ________

PLEASE REFER TO REVERSE PAGE FOR PATIENT RIGHTS INFORMATION

PATIENT SIGNATURE / LEGAL REP: ________ **DATE:** ________

If signed by other than patient, state relationship and authority to do so. *Please check appropriate box:*

☐ Parent of Minor ☐ Legal Guardian-attach court document ☐ POA for Healthcare-attach legal document
☐ Next of Kin of deceased ☐ Other ________

NOTE: I need the above records for an upcoming medical appointment on ________ (date).

DELIVERY: Unless noted otherwise, records will be sent directly to recipient. ☐ *Check here if patient wishes to pickup at the* ***HIM office on John Nolen Drive, Madison*** *on* ________ *(date).* [Please allow **minimum** of two (2) business days for processing your request.]