Black River Health

MRN_____

FIN_____

Release of Information Authorization

Employee initiating form: **Date/Time:**

1. Patient Information	**Name:**	Date of Birth	
	Previous Name:	Phone #	
	Address		
	City	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 ☐ All ☐ Other: _____		
	Address		
	City	State	Zip
	Attention: / Phone #	Fax #	
3. Where you want the information to be sent	**Name/Organization:**		
	Attention: / Phone #	Fax #	
	Address		
	City	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: _____		
Complete Section E if you are a minor authorizing disclosure of these specialized records	**<u>D. Records Requiring Specific Consent:</u>** ☐ Mental Health Treatment Notes ☐ HIV/AIDS Results ☐ Alcohol and/or drug treatment	**<u>E. Records Requiring Minor Consent are identified in bold.</u>** It is *recommended* that minor consents to release all other records in section E. ☐ **Alcohol and/or drug-detox only (12+yrs)** ☐ **HIV/Aids test results (14+yrs)** ☐ Outpatient mental health care (14+yrs) ☐ Rape or sexual assault/abuse (12+yrs) ☐ Sexually transmitted disease (17+yrs) ☐ Pregnancy test (17 yrs or younger) ☐ Pregnancy-related care or care of newborn (17 years or younger) _____ Patient signature _____ Date/Time	

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6. **When the information is needed by**	Date information is needed: _____ Date of the appointment: _____
7. **How would you like this information**	**Release Method/Format Requested**: 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: _____

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 and/or Copy of My Protected Health Information:** I have the right to inspect and receive copies of my protected health information as permitted by law. **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

BRH USE ONLY

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

Medical Records Released by:_____ Date/Time: _____

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