



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PLEASE NOTE:

- ◆ The name of the individual picking up medical records **must** be listed on the authorization. No one other than those listed will be granted access, including spouses.
- ◆ **Please have a photo ID available when picking up or viewing health records.**

Name of Patient: _____ Date of Birth: _____

Address of Patient: _____ Phone #: _____

Beloit Memorial Hospital
 1969 W Hart Rd
 Beloit, WI 53511-2230
 (P) 608-364-5011
 (F) 608-363-5798

Beloit Clinic
 1805 E Huebbe Pkwy
 Beloit, WI 53511-1842
 (P) 608-364-2200
 (F) 608-363-7390

Beloit Cancer Center
 1670 Lee Lane
 Beloit WI 53511-3935
 (P) 608-364-5253
 (F) 608-364-3194

Clinton Clinic
 307 Ogden Ave
 Clinton WI 53525-9007
 (P) 608-676-2206
 (F) 608-676-4029

Darien Clinic
 300 N Walworth
 Darien WI 53114-1532
 (P) 262-882-1151
 (F) 262-296-1195

Janesville Clinic
 1321 Creston Park
 Janesville WI 53545-1126
 (P) 608-757-1217
 (F) 608-757-1790

NorthPointe Campus
 5605 E Rockton Rd
 Roscoe IL 61073-7601
 (P) 608-525-4500
 (F) 608-525-4505

Occupational Health, Sports and Family Medicine Center
 1650 Lee Lane
 Beloit WI 53511-3935
 (P) 608-364-4666
 (F) 608-364-4670

West Side Clinic
 1735 Madison Rd
 Beloit WI 53511-3216
 (P) 608-363-7510
 (F) 608-363-7528

I hereby authorize and request:

BELOIT HEALTH SYSTEM

(Name and address of releasing facility)

To disclose to: **(ex: self, spouse, Dr., etc)**

(Name, address and phone number of individual, agency or organization)

Service Dates to be released: From _____ to _____

Specific information requested:

- | | | |
|--|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Radiology Films/Images | <input type="checkbox"/> HIV Test Results |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Operative/Procedure Reports | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Diagnostic Studies | <input type="checkbox"/> Drug/Alcohol |
| <input type="checkbox"/> Clinic Note | <input type="checkbox"/> Emergency Dept. Reports | <input type="checkbox"/> Abuse/Treatment |
| <input type="checkbox"/> Other _____ | | |

The purpose of this disclosure:

- Continued Medical Care
 Legal
 Personal
 Insurance
 Other (Specify): _____

I understand that I have the right to copy and inspect the information which is to be released. I further understand that the records contain information regarding the patient's medical condition and treatment and possibly could include information pertaining to drug and/or alcohol usage and/or mental health status and/or AIDS or HIV related illness.

It is further understood that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and submit this statement to Medical Records/Health Information Management at Beloit Health System. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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. Unless otherwise revoked, this authorization will expire on the following date or event: _____
 If I fail to specify an expiration date, this authorization will expire in six months. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may not be protected by federal confidentiality rules.

I understand that I am under no obligation to sign this form, and that Beloit Health System may not condition treatment or payment on my decision to sign this authorization except for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

 (Signature of patient or person authorizing consent) _____ (Date)

 (Relationship, if other than patient)

ADDITIONAL INFORMATION REGARDING RELEASE OF PATIENT INFORMATION

Beloit Health Systems recognizes the patient's right to confidentiality of medical records as in the Illinois and Wisconsin Statutes. Therefore, you should be aware of the following guidelines when requesting medical records.

Both Illinois and Wisconsin Statutes recognize the need for informed consent. The patient may request multiple releases of the information stated on the authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's signature. A new authorization is necessary for release of information on care provided after the date of your signature, **UNLESS** it is the authorization to release "future records of a specific test, specified clinic appointment and/or admission with the month and year identified."

All patients 18 years of age and over must sign for release of their own medical records unless the following conditions apply:

- * The patient is incompetent.
- * The patient is disabled and cannot sign the form.
- * The patient is deceased. (The surviving spouse or legal representative must sign authorization releasing records of the deceased person.)

Patients less than 18 years of age must sign for release of the medical records when:

- * The patient is 14 years of age or older and the records involve treatment for mental illness, alcoholism, or drug dependency.
- * The patient's records for release include abortion.

All persons signing for release of records, instead of the patient, must state their relationship to the patient and have available proof of legal authority to release the records.

For continuation of care, pertinent portions of your medical information will be sent to your physician/medical facility free of charge. All other requests are subject to fees. Some record requests may require pre-payment. If your request requires pre-payment an invoice will be sent to you with instructions on how to submit payments. If payment is required, the records will be sent after the payment is received.

If you have any questions regarding the above information, please do not hesitate to ask us.