Email: AspirusHealthInformation@aspirus.org

Mail to: **Aspirus Health Attn: HIM**
333 Pine Ridge Blvd
Wausau , WI 54401

Telephone Number: 715-847-2180

Fax Number:715-847-2187

1. Patient Information

NAME _____ Previous Name(s) _____

Date of Birth _____ Day phone _____ Email _____

2. Health Care Provider or Clinic or Hospital **who** has the information you want released?

NAME/ORGANIZATION _____ Phone _____

Address _____ Fax / Email _____

City _____ State _____ Zip _____

3. Where do you want the information to be sent?

NAME/ORGANIZATION Legal-Ease Digital Imaging Attention Pat Clifford

Address 2496 Meadowcroft Dr Phone 1-855-534-4003

City Burton State Michigan Zip 48519

Fax / Email 810-547-4030 - pat.legalease@gmail.com

4. ***Why*** is it needed?

☐ Continuing care ☐ Workers' Compensation ☑ Legal
☐ Insurance application ☐ School ☐ Personal Use ☐ Other _____

5. What are the approximate dates of information you want released?

Service Dates Between _____ **to** _____

What do you want released?

Select Records To Be Disclosed:

☐ Recent Wellness visit, Health Maintenance records (colonoscopy, bone density, pap, mammogram), Most recent two years of labs

☐ Admission Records
☐ History and Physical Exams
☐ Operative/Procedure Reports
☐ Emergency Reports
☐ Consultations
☐ Office Visit Notes
☐ Lab/Pathology Reports
☐ HIV/AIDS/STD's Testing
☐ Radiology Reports
☐ Immunizations
☐ Other Diagnostic Testing Results
☐ Behavioral Health Notes
☐ Chemical Dependency/Substance Abuse Reports
☐ Behavioral Health Admission
☐ Substance Abuse Admission
☐ Other (specify content and dates) _____

Information regarding alcohol and/or drug abuse or behavioral health will be released if requested **unless you restrict** by initialing:

_____ Do not release alcohol and/or drug abuse information _____ Do not release behavioral health information

_____ Do not release HIV/AIDS/STD's Testing Information

7. How do you want the information?

Release Method / Format requested:

For copies: ☐ MyAspirus ☑ Email: pat.legalease@gmail.com ☐ Fax

☐ *Other:* _____ ☐ Verbal (no copies)

- This authorization is effective for one year from the date signed, or on occurrence of the following event (Specify): _____
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing at any time, except to the extent that the authorization was acted upon prior to revocation.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand that Aspirus Health may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- I understand that fees may apply to process my medical record request. I understand that in compliance with MN Statute 144.292 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records an/or supervising inspection of medical records. There is no charge for records requested by and released to other healthcare organizations. See www.aspirus.org for more details on fees assessed.
- I understand a photocopy or fax of this form is the same as the original.
- The information disclosed is protected by Federal confidentiality rules (42 CFR Part 2), and is intended only for the confidential use of the requester. The Federal rules strictly prohibit anyone from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder, unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

8. Patient **Signature** and **Date** are required to release records. If an **Authorized Person** is signing you must include **legal documentation**.

_____
Patient Signature

_____
Date

_____
Signature of Authorized Person

☐ Parent of Minor ☐ Court-appointed guardian/conservator
Include legal documentation

_____
Date

Authorization For Use and Disclosure of Protected Health Information