

Page 1 of 3

9-84541 © 2023 Marshfield Clinic Health System

Patient Name:	MRN:	DOB:	Sex:
5. What information you want released (continued) <i>Complete section F if need any of these records</i>	F. <u>Radiology Films, Pathology Slide or Photographs</u> **All loaned films & slides must be returned within 30 days** ☐ Radiology Images: _____ ☐ Pathology slides: _____ ☐ Photographs (define type): _____ ☐ Date Mailed: _____ Date Picked Up: _____ By _____		
6. When information is needed by	Date information is needed: _____ or Date of the Appointment: _____ To check on the status of your request: call 1-800-782-8581, Ext. 93676, option 3 or email medicalrecords@marshfieldclinic.org To check on the status of FMLA/Disability/Other Form: call 1-800-782-8581, Ext. 93676, option 2 or email disability@marshfieldclinic.org		
7. How would you like this information?	<u>Release Method/Format Requested:</u> <i>Note: Information supplied electronically is in PDF format and is encrypted</i> ☐ Mailed ☒ Faxed ☐ USB drive ☒ CD/DVD ☒ Email: <u>pat.legalease@gmail.com</u> Other: <u>asf</u>		
8. Expiration	This authorization is effective for one year after the date of signature unless otherwise indicated _____		

Patient Signature

Date/Time

Printed Name

Signature of Authorized Person

Date/Time

(Relationship)

Printed name

☐ Parent of Minor ☐ Court appointed guardian/conservator - include legal documentation
Wisconsin Authorizations:
Mail Form to: MCHS, 1000 North Oak Avenue, Marshfield, WI 54449
 ATTN: Health Information Management, 1N

Fax Form to: 715-221-6992
Email Form to: medicalrecords@marshfieldclinic.org
Wisconsin - FMLA/Disability/Other Form Authorizations:
Mail Form to: MCHS, 1000 North Oak Avenue, Marshfield, WI 54449
 ATTN: Health Information Management, HM2

Fax Form to: 715-221-5847
Email Form to: disability@marshfieldclinic.org
Michigan Authorizations:
Mail Form to: MMC-Dickinson, 1721 S. Stephenson Ave, Iron Mtn, MI 49801
 ATTN: Health Information Management - ROI

Fax Form to: 715-221-6992
Email Form to: medicalrecords@marshfieldclinic.org

Patient Name:	MRN:	DOB:	Sex:
---------------	------	------	------

Redisclosure notice to patient: If the person(s) and/or organization(s) listed on the front side are not health care providers, health care clearinghouses, or health plans, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose your health information.

Disclosure notice to recipient of patient health care records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your rights with respect to this authorization

- *Right to receive copy of this authorization* – You have the right to receive a copy of this authorization.
- *Right to refuse to sign this authorization* – You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding:
 - research-related treatment
 - health plan enrollment or eligibility
 - the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party
- *Right to withdraw this authorization* – You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact the Health Information Management (medical records) department. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- *Right to inspect a copy of the health information to be used or disclosed* – You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form. You may arrange to inspect your health information or obtain copies of your health information by contacting the Health Information Management (medical records) department.
- *HIV test results* – Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- *Mental health treatment records* – You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.
- *Reproductive Health Care Records* - The HIPAA Privacy Rule provides specific protections for reproductive health care records, requiring an attestation (prior to release), declaring that the records will not be used or disclosed for prohibited purposes when requested for: health oversight activities; judicial and administrative proceedings; law enforcement purposes; or coroners/medical examiners about decedents.