

ProHealth Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-262-928-4465 (VRS: 1-866-327-8877).
 ATENCIÓN: Si habla español, tenemos a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-262-928-4465 (VRS: 1-866-327-8877).
 LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-262-928-4465 (VRS: 1-866-327-8877).

PATIENT INFORMATION:

Name of Patient/Previous Names _____	Birth Date _____	Medical Record Number _____
Street Address _____	City, State, Zip _____	Phone Number _____

AUTHORIZES DISCLOSURE BY:

☐ ProHealth Care Oconomowoc Memorial Hospital ☐ ProHealth Care Behavioral Health Services ☐ PHMG, Specify Clinic/Provider _____ ☐ ProHealth Waukesha Memorial Hospital - Mukwonago Campus ☐ Other (Name of Health Care Provider/Plan/Other): _____	☐ ProHealth Care Pharmacy ☐ ProHealth Care Waukesha Memorial Hospital ☐ ProHealth Medical Group Occ Health, Specify Site _____ ☐ ProHealth Solutions Participant _____
Street Address _____ City, State, Zip Code _____	

DISCLOSURE OF HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other Legal-Ease Digital Imaging, LLC - Pat Clifford
 Street Address 2496 Meadowcroft Dr City, State, Zip Code Burton, MI 48519

INFORMATION TO BE DISCLOSED:

CLINIC		HOSPITAL	
☐ Clinic Records 2-3 Year Summary (general abstract includes Progress Notes, Consults, Labs & Radiology Reports)		☐ Hospital Summary (general abstract includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports and ED Report)	
☐ Entire Medical Record	☐ Mental/Behavioral Health	☐ Entire Medical Record	☐ Mental/Behavioral Health
☐ History & Physical	☐ Radiology Films	☐ History & Physical	☐ Radiology Films
☐ Office Visit Notes	☐ Radiology Report	☐ Progress Notes	☐ Radiology Report
☐ Operative/Procedure Report	☐ Rehab Notes (PT, OT, Speech)	☐ Consultation	☐ Rehab Notes (PT, OT, Speech)
☐ Laboratory Report	☐ Billing Records	☐ Operative/Procedure Report	☐ Billing Records
☐ Pathology Report		☐ Discharge Summary	☐ Pathology Report
☐ Other _____		☐ Laboratory Report	☐ Prescription History
☐ Other _____		☐ Other _____	

DISCLOSURES REQUIRING SPECIAL CONSENT: In compliance with Wisconsin Statutes and federal law, which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply. ☐ HIV/AIDS* ☐ Substance Use (Abuse) Disorder** ☐ SANE ☐ SANE Photos
 All information, including the information listed as "Clinic" and "Hospital" above and substance use (abuse) disorder counseling notes, will be disclosed under this authorization, except: _____ (please list information).

FOR THE FOLLOWING DATES: From: _____ To: _____

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

☐ Continuing Care
 ☐ Transfer to New Provider
 ☐ Insurance/Claim Purposes
☒ Legal
☐ Personal Use
☐ Disability Determination
☐ Workers Compensation
☐ Vocational Rehab Eval
☐ Other _____

Check One: ☐ Verbal Release ☐ Paper Release ☐ View ☐ Electronic/Digital Release (specify) _____
 Release by: ☐ US Mail ☐ MyChart ☒ Fax 810-547-4030 ☐ Pick-Up: Location _____

PROHEALTH CARE
 ORIGINAL - Medical Records

PATIENT LABEL



YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Receive a Copy of the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) of the health information I have authorized to be used or disclosed by this authorization form.

Right to Receive Copy of This Authorization – I understand that if I agree to sign this authorization, I may receive a copy.

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that ProHealth Care may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to ProHealth Care's Release of Information Department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organizations(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards.

***HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State laws and a list of those persons/organizations is available upon request.

****Substance Use (Abuse) Disorder Information:**

This information has been disclosed to you from ProHealth substance use (abuse) disorder program records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The patient may revoke this consent at any time except to the extent that persons disclosing or receiving the information have acted in reliance on the consent.

The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

EXPIRATION DATE: This authorization is effective until _____ or one year from the date signed, and includes records that were created or existed on or before the date this authorization was signed.

☐ This includes records that are created after the date this authorization is signed, up until the expiration date.
_____(initials)

SIGNATURE OF PATIENT/LEGAL REP: _____ **DATE:** _____ **TIME:** _____

If signed by a person other than the patient, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care

*By signing above, I hereby declare that I have not been denied physical placement of this minor child.

Information Released By: _____ **DATE:** _____ **TIME:** _____

Number of Pages Released: _____

PROHEALTH CARE

ORIGINAL - Medical Records

PATIENT LABEL

