Patient Name			
Patient #	DOB	Age	Gender

Release or Share

KCHC
KENOSHA COMMUNITY HEALTH CENTER, INC.

Release of Information Authorization

For the purpose* of sharing information with a family member *complete sections A, B, C, E, J & K.
For the purpose of* releasing information *completed sections: A, B, C, D, F, G (minors only), H, I, J & K.

A: Patient

Previous last name (if any)		
Address	Daytime phone number	
City	State	Zip

B: Who has the information that is to be released

☐ KCHC-**Medical/Behavioral Health**
4536 22nd Avenue
Kenosha, WI 53140
Phone: 262-656-0044
Fax: 262-653-2218

☐ KCHC-**Dental**
6226 14th Avenue
Kenosha, WI 53143
Phone: 262-656-0044
Fax: 262-925-1680

C: To whom the information should be released

Name	Attention	Phone Number
Address	Fax	
City	State	Zip

D: Medical records or other records to be disclosed.

Check (√) box(es) of the records to be released per this request (if minor is signing this authorization, see section titled "Special medical record release by minor")

Medical and/or Dental records:	☐Consults	☐Correspondence	☐X-ray reports (See Section F)
☐Medical History and notes	☐Dental	☐HIV/AIDS test results	☐Other diagnostic tests
☐Laboratory reports	☐Prescriptions	☐Hospital records	☐Third-party records
☐Billing/Financial records	☐ Immunizations	☐School records	☐Behavioral Health records

☐By specific doctor, for a specific diagnosis or a specific date range

☐Other, specify

Mental health/alcohol & other drug abuse/psychology records:

☐Mental health AND/OR ☐ Alcohol & other drug abuse AND/OR ☐ Neuropsychology

☐Medication treatment	☐Consult	☐Correspondence	☐Discharge summary
☐Testing evaluation	☐Evaluation	☐Treatment notes	☐Third-party records
☐Emergency room note	☐Treatment plan		

☐ By specific doctor, for a specific diagnosis or a specific date range

☐ Other, specify

E: Medical or other records to be shared with relatives or other persons

Check (√) box(es) to indicate the information you want shared.

☐ Medical information: written, verbal and/or voicemail appointment verification (excluding mental health treatment, AODA treatment, HIV test results)

☐ Dental information: written, verbal and/or voicemail appointment verification

☐ Behavioral Health information: written, verbal and/or voicemail appointment verification

AND/OR check individual items below that can be shared:	☐Treatment of HIV/AIDS, including test results
☐Alcohol and other drug therapy	☐ Dental records
☐Psychology notes	☐ Labs and x-rays
☐My patient number	☐Mental health treatment notes

☐Billing information about my account which may include health information

☐ My spouse or parent can access my electronic medical and/or dental record (EMR)

☐ Specific information as follows: Diagnosis

Provider Date range

Release of Information Authorization (Continued)

Patient Name	Patient #	DOB	Age	Gender

F: Radiology films, lab results, or photographs to be disclosed

Check (√) box(es) below for the films, lab results or photographs to be released per this request:

☐Original x-ray of ☐Mailed date (m/d/y) / /

☐Photographs (return loaned films/slides within 30 days)

(define type) ☐Pick up date (m/d/y) / /

☐Lab results of By

G: Special medical record release By minor

I am a minor and I have received medical care that requires or allows me to consent to the release of medical records of this care to my parents or anyone else.

Check (√) boxes of medical records to be disclosed:

☐Outpatient alcohol or other drug dependency care (12 years or older) *(parent may also be required to sign below)*

☐Inpatient alcohol or other drug dependency care – detoxification only (12 years or older) *(parent may also be required to sign below)*

☐Rape or sexual assault/abuse (12 years or older) *(parent may also be required to sign below)*

☐Outpatient mental health care (14 years or older)

☐Inpatient mental health care (14 years or older)

☐Neuropsychology notes (14 years or older) *(parent may also be required to sign below)*

☐HIV/AIDS test results (14 years or older)

☐Sexually transmitted disease (17 years or younger)

☐Pregnancy test (17 years or younger) *(parent may also be required to sign below)*

☐Birth control pills or devices (17 years or younger) *(parent may also be required to sign below)*

☐Pregnancy-related care or care of newborn (17 years or younger)

☐My parent (a physician at KCHC) can access my electronic record (EMR) *(parent may also be required to sign below)*

Patient signature _____ Date (m/d/y) _____/_____/_____

H: Method of release

☐Electronic (via CD/DVD) ☐Paper

Note: Information supplied via CD/DVD is in PDF format and is not encrypted.

I: Reason for the Release

Check (√) box below to indicate the reason for the release per this request:

☐Continuing health care needs
☐Disability
☐Transfer of care
☐Care coordination or case management
☐Second opinion/referral
☐Personal
☐Financial assistance
☐Preemployment or medical evaluation
☐Billing, collection or payment of claims
☐Postemployment testing or medical
☐Employment determination (nonwork-related Illness or injury)
☐Litigations
☐Other, specify:

Release of Information Authorization (Continued)

Patient Name	Patient #	DOB	Age	Gender

J: Expiration Check (√) box(es) to indicate the information you shared.	This authorization will remain in effect:
	☐From the date this authorization is signed until the day of , 20 .
	☒Until you cancel this authorization in writing.
	☐Until the following event occurs (specify event:)
	☐Other (specify:)

K: By signing this, you specifically authorize the use and disclosure of the information you selected above. You acknowledge that you have reviewed and understand this authorization form, including the notions below.

_____	_____	_____/____/_____	_____
Patient signature (Patient's legal representative)	(Relationship)	Date (m/d/y)	Phone number

Send the completed authorization to Release of Medical Information, 4536 22nd Avenue, Kenosha, WI 53140.

Note: This authorization will be returned and records will be delayed if all required sections are not completed.

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, 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 a 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 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 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 that have 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.