AUTHORIZATION TO VIEW/DISCLOSE HEALTH INFORMATION

Last Name (& Maiden, if applicable): ___________________ First: ____________________ Middle: ________________

Address: ____

Date of Birth: ______________ Sex: ____________ Phone Number: ______________________

I authorize the use or disclosure of the above named patient's health information as described below:

FROM: ☐ Wheaton Franciscan Medical Group
All Racine County Locations

☐ WFH-All Saints (aka: St. Mary's)
3801 Spring Street
Racine, WI 53405

☐ WFH-All Saints (aka: St. Luke's)
1320 Wisconsin Avenue
Racine, WI 53403

TO:
Name: **Heritage Health Services**
Address: **6634 Durand Ave**
City, State, Zip: **Racine, WI 53406**
Phone: **262-554-8800** Fax: **844-505-8800**

FOR THE PURPOSE OF: (Check all that apply.)
☐ Transfer of Primary Care ☐ Continued Care ☐ Legal ☐ Insurance ☐ Personal Use ☐ Other: ____________________

INFORMATION TO BE VIEWED AND/OR DISCLOSED:
Date(s) of Treatment: ________________________________ ☐ Schedule Appointment to View Record Only (no copies)

☐ Complete Record

☐ Record Abstract (two-year history of pertinent information unless otherwise stated above)

☐ Discharge Summary ☐ History & Physical ☐ Emergency Record ☐ Operative Record ☐ Progress Notes

☐ Lab Results, date or type: _____________________ ☐ Radiology Reports, dates or type: ________________________

☐ Radiology Film / CD, dates or type ________________________________ Date Sent to Radiology ________________

☐ Immunization Record ☐ Other: ____

PLEASE CHECK IF YOU DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:
☐ HIV/AIDS (including test results) ☐ Substance Abuse Record ☐ Mental Health Treatment Records

I understand that the information in my health record may include information relating to mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that if I refuse to authorize the disclosure of information, the information may not be released. I further understand that HIV test results may be disclosed without my permission in certain circumstances and that a list of such circumstances is available to me upon request. I further understand that I have a right to receive a copy of any mental health treatment record to be disclosed.
I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected by such laws. I understand that I have a right to revoke this authorization at any time. I can do so by submitting my revocation in writing to Health Information Services. I understand that my revocation will not apply to information that has already been released in response to this authorization.

This authorization expires 365 days from the date this authorization is signed unless otherwise noted: _____________________

This authorization is voluntary. Wheaton Franciscan Healthcare will not condition your treatment on this authorization. A copy of this authorization will be considered as valid as the original.

Signature of Patient or Authorized Representative: ____ Date: __________

If Signed by Authorized Representative, Relationship to Patient: ____
(If you are signing as a parent of the minor patient listed above, you are declaring that you have not been denied physical placement or parental rights of the child because such placement would endanger the child's physical, mental, or emotional health)

Witness Signature (when applicable): ____ Date: _________

If unable to sign document, give reason: ____

For office use: Identification Verified: ___________ (initials) Signature Verified: _____________ (initials)