RELEASE OF INFORMATION and AUTHORIZATION TO DISCLOSE

BAYCARE CLINIC

MRN: (Office Use Only) _____

Medical Records related to care provided in a hospital or surgery center, such as the Emergency Department or Anesthesia services at a facility, are maintained by and can be obtained from the facility where the service was provided. ***Many BayCare Clinic records can be requested and received at no charge via the myBayCare patient portal: https://my.baycare.net/BaycareClinicsMyChart/***

Please complete sections 1-8. If you have questions about this form, please call 920-544-5414.

1. _____

Name Address City State Zip

_____ _____ _____

Telephone Number Date of Birth Last 4 of SSN

2. Authorizes (Select 1)**:**

☐ BayCare Clinic (Specify **ALL** Providers/Departments or List individual Providers/Departments)_____

☐ Other Provider/Office/Facility_____Address: _____

City, State, Zip Code_____Phone: _____Fax: _____

3. To Disclose/Send Records To (Select 1):

☐ BayCare Clinic (Specify Providers/Departments)

_____

☐ Other***: (FILL IN)*** Name: _____Address: _____

City, State, Zip Code: _____Phone: _____Fax: _____

Email address: _____

4. INFORMATION TO DISCLOSE (check all applicable)

Dates: From_____to_____

□ Office Notes □ X-Ray Reports

□ Lab □ Billing Records

□ BayCare Clinic Radiology Images

(Specify Images for CD):_____

□ Other_____

5. DELIVERY METHOD

□ Verbal

□ Online – via myBayCare patient portal

Fee may apply:

□ Mail

□ Fax to_____

□ Pickup Records

□ Digital (CD)

□ Encrypted Email (must provide address in #3 above)

6. PURPOSE FOR DISCLOSURE

□ Legal

□ Insurance (includes Work Comp)

□ Personal

□ Continuing Care

□ Other: _____

(e.g. FMLA, athletics, employment)

CHECK BOXES BELOW TO ALLOW FOR DISCLOSURE OF THE FOLLOWING:

☐Mental Health Treatment Records ☐Substance Use Disorder Treatment Records ☐Developmental Disability Treatment Records ☐HIV Status

7. This authorization is valid until the **earlier** of one year from the date of signature below or the following date: _____

I understand that: I can revoke this authorization in writing, which will be effective upon receipt by the BayCare Clinic Release of Information Department. Signing this form authorizes the release of information to the entities above; this means that should that entity re-disclose my protected health information, the information may no longer be protected within the guidelines of federal privacy standards. I have a right, upon written request, to inspect the materials disclosed and that this inspection is at no cost to me and will be in the presence of a BayCare Clinic employee. I understand that I can receive a copy of the materials disclosed as required by law and that I am responsible for all associated copying fees that are charged in accordance with Wisconsin Statutes. Information relating to my treatment may be released upon my agreement or as otherwise specified by 42 CFR, 45 CFR 164.508 and Wisconsin State Statutes 51.30, 146.025 and 146.81. My signature on this form is not required for me to receive treatment. I have read and understand the contents of this form and may request a copy of this form.

_____ _____

8. Signature of Patient or Representative Date Printed Name

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

- Patient is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
- I am the patient's: ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care ☐ foster parent

RELEASE OF INFORMATION and AUTHORIZATION TO DISCLOSE

BayCare Clinic

MRN: (Office Use Only) _____

Medical Records related to care provided in a hospital or surgery center, such as the Emergency Department or Anesthesia services at a facility, are maintained by and can be obtained from the facility where the service was provided. ***Many BayCare Clinic records can be requested and received at no charge via the myBayCare patient portal: https://my.baycare.net/BaycareClinicsMyChart/***

Please complete sections 1-8. If you have questions about this form, please call 920-544-5414.

1. **Fill in ALL patient demographics**

Name _____ Address _____ City _____ State _____ Zip _____

Telephone Number _____ Date of Birth _____ Last 4 of SSN _____

2. Authorizes (Select 1): **Select first box for BCC to release records**

Select second box if BCC is to receive records, and fill in ALL information

☐ BayCare Clinic (Specify **ALL** Providers/Departments or List individual Providers/Departments)_____

☐ Other Provider/Office/Facility_____Address: _____

City, State, Zip Code_____Phone: _____Fax: _____

3. To Disclose/Send Records To (Select 1):

Select first box if BCC is the receiver

Select second box for BCC to send records to, and fill in ALL information

☐ BayCare Clinic (Specify Providers/Departments) _____

☐ Other***: (FILL IN)*** Name: _____Address: _____

City, State, Zip Code: _____Phone: _____Fax: _____

Email address: _____

Box 4 must have dates AND record types

4. INFORMATION TO DISCLOSE (check all applicable)

Dates: From_____**to**_____

- ☐ Office Notes
- ☐ X-Ray Reports
- ☐ Lab
- ☐ Billing Records
- ☐ BayCare Clinic Radiology Images

(Specify Images for CD):_____

☐ Other_____

Box 5 select how to receive records

5. DELIVERY METHOD

- ☐ Verbal
- ☐ Online – via myBayCare patient portal
- Fee may apply:
  - ☐ Mail
  - ☐ Fax to_____
  - ☐ Pickup Records
  - ☐ Digital (CD)
  - ☐ Encrypted Email (must provide address in #3 above)

Box 6 is reason for records

6. PURPOSE FOR DISCLOSURE

- ☐ Legal
- ☐ Insurance (includes Work Comp)
- ☐ Personal
- ☐ Continuing Care
- ☐ Other: _____ (e.g. FMLA, athletics, employment)

CHECK BOXES BELOW TO ALLOW FOR DISCLOSURE OF THE FOLLOWING:

☐Mental Health Treatment Records ☐Substance Use Disorder Treatment Records ☐Developmental Disability Treatment Records ☐HIV Status

7. This authorization is valid until the **earlier** of one year from the date of signature below or the following date: _____ **Only add date here if you want form to be valid for less than one year**

I understand that: I can revoke this authorization in writing, which will be effective upon receipt by the BayCare Clinic Release of Information Department. Signing this form authorizes the release of information to the entities above; this means that should that entity re-disclose my protected health information, the information may no longer be protected within the guidelines of federal privacy standards. I have a right, upon written request, to inspect the materials disclosed and that this inspection is at no cost to me and will be in the presence of a BayCare Clinic employee. I understand that I can receive a copy of the materials disclosed as required by law and that I am responsible for all associated copying fees that are charged in accordance with Wisconsin Statutes. Information relating to my treatment may be released upon my agreement or as otherwise specified by 42 CFR, 45 CFR 164.508 and Wisconsin State Statutes 51.30, 146.025 and 146.81. My signature on this form is not required for me to receive treatment. I have read and understand the contents of this form and may request a copy of this form.

Patient or legal rep must sign AND date _____ **Printed name of signer here** _____

8. Signature of Patient or Representative _____ Date _____ Printed Name _____

If signed by a person other than the patient, complete the following: **Only complete if patient did not sign form**

- Patient is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
- I am the patient's: ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care ☐ foster parent