RELEASE OF INFORMATION and AUTHORIZATION TO DISCLOSE

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 & 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

□ 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 following date: _____

I understand that:I can revoke this authorization in writing, which will be effective upon receipt by 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; a copy shall be provided to the patient upon request. I have read and understand the contents of this form.

_____ _____

8. Signature of Patient or Representative Date Printed Name

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

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