

## 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 and received at no charge via the myBayCare patient portal:* <a href="https://my.baycare.net/BaycareClinicsMyChart/">https://my.baycare.net/BaycareClinicsMyChart/</a>
Please complete sections 1-8. If you have questions about this form, please call 920-544-5414.

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/D	epartments)								
☐ Other Provider/Office/Facility	Other Provider/Office/FacilityAddress:									
City, State, Zip Code	Phone:			Fax:						
3. To Disclose/Send Records To (Select 1):  ☐ BayCare Clinic (Specify Providers/Departments)										
☐ Other: (FILL IN) Name: City, State, Zip Code:		_Address:								
				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):	5. DELIVERY METH  Verbal  Online – via myBa Fee may apply:  Mail  Fax to  Pickup R  Digital (C	yCare <u>patient</u> portal	□ Le □ In □ Pe □ C							
- Other		ı #3 above)								
CHECK BOXES BELOW TO ALLOW FOR DISCL	OSURE OF THE FO	I I OWING:								
☐Mental Health Treatment Records ☐Substance Use Disord			y Treatmer	nt Records 🔲 H	IV Status					
7. This authorization is valid until the earlier of one year f	rom the date of signatur	e below or the followir	na date.							
I understand that: I can revoke this authorization in writinformation Department. Signing this form authorizes the entity re-disclose my protected health information, the standards. I have a right, upon written request, to inspect to in the presence of a BayCare Clinic employee. I unand that I am responsible for all associated copying feet to my treatment may be released upon my agreement Statutes 51.30, 146.025 and 146.81. My signature on the understand the contents of this form and may request an entity of the statutes of the contents of this form and may request an entitle of the contents of this form and may request an entitle of the contents of this form and may request an entitle of the contents of this form and may request an entitle of the contents of this form and may request an entitle of the contents of this form and may request an entitle of the contents of this form and may request an entitle of the contents of the	iting, which will be effethe release of information may no looked the materials discloderstand that I can recest that are charged in or as otherwise specithis form is not require	ective upon receipt by ion to the entities aborger be protected with osed and that this insceive a copy of the maccordance with Wisfied by 42 CFR, 45 C	y the Bay ove; this r thin the gu spection is aterials di sconsin Si CFR 164.5	Care Clinic Remeans that should lines of fects at no cost to isclosed as rectatutes. Inform 508 and Wisco	elease of could that deral privacy me and will quired by law ation relating onsin State					
8. Signature of Patient or Representative	Date Pri	inted Name								
If signed by a person other than the patient, con  • Patient is: □ a minor □ legally incompetent										

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

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:* <a href="https://my.baycare.net/BaycareClinicsMyChart/">https://my.baycare.net/BaycareClinicsMyChart/</a>
Please complete sections 1-8. If you have questions about this form, please call 920-544-5414.

1.	F	Fill in ALL patient demographics							
	Name		Address	City	,	State	Zip		
	Telephone Number Select first box fo		Date of Birth			Last 4 of SS	N		
2.	Authorizes (Select 1):  BayCare Clinic (Specify ALL Providers/Department)	if BCC tments or	is to receive records, ar List individual Providers/Departme	nd fill in ALL inf ents)_	formati	on			
	☐ Other Provider/Office/Facility								
	City, State, Zip Code		Phone:		Fax				
3.	To Disclose/Send Records To (Select 1):  ☐ BayCare Clinic (Specify Providers/Departm	ante I	lect first box if BCC is the lect second box for BCC t		to, and	fill in ALL	information		
	☐ Other: (FILL IN) Name:		Addre	ss:	<b>&gt;</b>				
	City, State, Zip Code:		Phone:			_Fax:			
	Email address:								
	Box 4 must have dates AND record typ	oes	Box 5 select how to re	eceive records	Box 6	is reason	for records		
	A. INFORMATION TO DISCLOSE (check all applementation)  Dates: Fromto  Office Notes		5. DELIVERY METHOD  Verbal Online – via myBayCare Fee may apply: Mail Fax to Pickup Records Digital (CD) Encrypted Emai	I (must provide	□ Leg □ Insu □ Pers □ Cor	al urance (includ sonal ntinuing Care er:	DISCLOSURE les Work Comp)		
	CHECK BOXES BELOW TO ALLOW FOR DIS								
_	☐ Mental Health Treatment Records ☐ Substance U  This authorization is valid until the earlier of one year.			· · · · · · · · · · · · · · · · · · ·					
I D pi ul C as m si	understand that: I can revoke this authorization epartment. Signing this form authorizes the relegate rotected health information, the information may be poon written request, to inspect the materials disclinic employee. I understand that I can receive a sociated copying fees that are charged in according agreement or as otherwise specified by 42 C gnature on this form is not required for me to repay of this form.	in writing ase of in no longe closed ar copy of rdance v FR, 45 C	g, which will be effective upon formation to the entities above er be protected within the guid not that this inspection is at no the materials disclosed as req with Wisconsin Statutes. Inforr FR 164.508 and Wisconsin S	receipt by the Bay e; this means that elines of federal p cost to me and wi uired by law and to nation relating to relate Statutes 51.3	yCare Cli should the rivacy statill be in the that I am my treatm 0, 146.02	or less than inic Release hat entity re-candards. I have presence cresponsible finent may be 25 and 146.8	one year of Information disclose my ve a right, of a BayCare or all released upon 1. My		
	Patient or legal rep must sign	AND d	ate	Printed	l name	of signer l	nere		
	. Signature of Patient or Representative		Date	Printed Nan					
lf	<ul> <li>signed by a person other than the patie</li> <li>Patient is: □ a minor □ legally incom</li> </ul>		-		atient o	did not sig	n form		
	I am the patient's: □ legal guardian □	next of	kin/executor of deceased	☐ activated POA	A for Hea	alth Care □	foster parer		