

## AUTHORIZATION TO RECEIVE HEALTH INFORMATION FROM ANOTHER FACILITY

Name – Last, First MI			
2	G.		
Street Address	City	State	Zip
Medical Record/Member # Date	e of Birth (MM/DD/YYYY)	Phone number	er
	/ /		
. RELEASED FROM:	3. DISCLOSE	D TO:	
Name of Healthcare Provider/Organization/Individual	ATTN: Healt	Group Health Cooperative of South Central Wisconsin (GHC-SATTN: Health Information Management 1265 John Q Hammons Drive Madison, WI 53717-1962 Phone: (608) 251-4156 Fax: (608) 221-2646	
Street Address	Phone: (608)		
City State Zip	= Fax: (608) 22	21-2040	
. PURPOSE OF THIS DISCLOSURE: The purpose of this disclosure is for continuation of continuati	care/transferring care.		
. INFORMATION TO BE DISCLOSED & FOR	RMAT:		
Date Range:			
Office Notes Immunization Records	Eye Care Notes R	adiology Notes	
Problem List/Health Summary PT/O	Γ Lab Reports M	Andination Tint	
	1 Lau Reports IV	Iedication List	
Specific information pertaining to:	· 		to authorize release:
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## Guidelines for Completion of Authorization to Receive Medical Information from Another Facility

- 1. This form can be used to obtain medical records from another health care facility.
- 2. Complete the patient's name, SS#, daytime phone #, and date of birth.
- 3. Complete the name and address of the person/facility that the records are to be obtained from.
- 4. Identify the appropriate dates of service for the records that are to be obtained.
- 5. Check the appropriate information that is to be released (copied and/or faxed).
- 6. Review your rights for this authorization.
- 7. Review the expiration date of the authorization. If you would like a different expiration date, please indicate.
- 8. Obtain the patient or legal representative's signature (relationship) and date.
- 9. If this request relates to AIDS/HIV, Mental Health Care, Alcohol/Drug Use, or Development Disabilities, please sign and date under the specified section.
- 10. Mail the completed request to your previous health care facility. You may need to contact your previous clinic for information on where to mail or fax the completed form. If this is sent to Group Health Cooperative of South Central Wisconsin (GHC-SCW), this will only delay the process of your GHC-SCW provider receiving copies of your prior health records.

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11. Your previous clinic will process your request, and send the information to GHC-SCW.