Group Health Cooperative
of South Central Wisconsin

AUTHORIZATION TO RECEIVE HEALTH INFORMATION FROM ANOTHER FACILITY

1. PATIENT INFORMATION

Name – Last, First MI			
Street Address	City	State	Zip
Medical Record/Member #	Date of Birth (MM/DD/YYYY) / /	Phone number	

2. RELEASED FROM:

Name of Healthcare Provider/Organization/Individual

Street Address

City State Zip

3. DISCLOSED TO:

Group Health Cooperative of South Central Wisconsin (GHC-SCW)
ATTN: Health Information Management
1265 John Q Hammons Drive
Madison, WI 53717-1962
Phone: (608) 251-4156
Fax: (608) 221-2646

4. PURPOSE OF THIS DISCLOSURE:

The purpose of this disclosure is for continuation of care/transferring care.

5. INFORMATION TO BE DISCLOSED & FORMAT:

Date Range: _____ (MM/DD/YYYY) TO _____ (MM/DD/YYYY)

☐ Office Notes ☐ Immunization Records ☐ Eye Care Notes ☐ Radiology Notes
☐ Problem List/Health Summary ☐ PT/OT ☐ Lab Reports ☐ Medication List

☐ Specific information pertaining to: _____

Federal and state laws require special permission to release certain information. Check applicable boxes to authorize release:

☐ Mental Health ☐ Alcohol/Drug Use ☐ Developmental Disabilities ☐ AIDS/HIV

6. MY RIGHTS REGARDING THIS AUTHORIZATION

Right to inspect or receive a copy of the health information to be used or disclosed: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for healthcare benefits on my decision to sign this authorization.

Right to revoke this authorization: I understand that written notification is necessary to revoke this authorization. To obtain information on how to revoke my authorization or to receive a copy of my withdrawal, I may contact GHC-SCW. I am aware that my revocation will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. GHC-SCW will not condition treatment on the completion of this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I understand that this information may be released electronically.

EXPIRATION DATE: This authorization is effective for one (1) year from the date signed unless otherwise indicated. _____/_____/_____ (MM/DD/YYYY)

Signature of Patient or Legal Representative _____ **Date:** _____/_____/_____ (MM/DD/YYYY)

Relationship: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Spouse of Deceased
☐ Health Care Agent ☐ Personal Representative
☐ Other: _____

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