Group Health Cooperative
of South Central Wisconsin

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FROM GHC-SCW

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:

Group Health Cooperative of South Central Wisconsin (GHC-SCW)
ATTN: Release of Information Department
5249 E Terrace Dr
Madison, WI 53718
Phone: (608) 441-3500
Fax: (608) 441-3499
E-mail completed authorization to: ghcroi@ghcscw.com

3. DISCLOSED TO:

_____
Name of Provider/Organization/Individual/Other

_____
Street Address

_____
City State Zip

4. PURPOSE OF THIS DISCLOSURE:

☐ Transferring Care/Continuity of Care (Customary to release up to 2 years of most recent information)
☐ Insurance Application ☐ Disability Determination ☐ Payment of Claims/Benefits ☐ Legal Use
☐ Personal Use ☐ Other: (Specify) _____

5. INFORMATION TO BE DISCLOSED & FORMAT:

☐ Paper **OR** ☐ DVD -- ☐ MyChart (Personal requests only)

Date Range: ____ / ____ / ____ to ____ / ____ / ____
MM DD YYYY MM DD YYYY

☐ Office Visits ☐ Immunization Records ☐ Eye Care Notes ☐ Radiology Notes ☐ **Radiology Reports** →
☐ PT/OT ☐ Complementary Medicine ☐ Lab Reports ☐ Medication List ☐ Procedures
☐ Specific information pertaining to: _____

Medical Imaging Requests
Hatchery Hill Clinic
3051 Cahill Main
Fitchburg, WI 53711
Fax: (608) 661-7210
Call: (608) 661-7354

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: _____ Legal Authority: ☐ Legal Guardian ☐ Spouse of Deceased
Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased ☐ Health Care Agent ☐ Personal Representative
☐ Other: _____

Instructions and Important Disclosure Information: Below you will find instructions for completion of this form, important information about your privacy rights, how we ensure your information is collected, used and disclosed in accordance with applicable laws and policies and our pledge to ensure and protect your privacy in this process. Patients may submit complaints about this process at any time by contacting the GHC-SCW Privacy Officer or the HIM Manager.

1. Print patient's name, address, phone number, date of birth and medical record (GHC-SCW) number.
2. Confirm authorization relates to GHC-SCW records. GHC-SCW may be prohibited from disclosure of records pertaining to other health care providers.
3. Print the name and address of the organization or individual to whom you wish to release records.
4. Check the box indicating the purpose of this disclosure.
5. (a) Insert the date range for which you are requesting release of records; (b) Check the box(es) indicating the format in which the records should be disclosed (e.g. paper, DVD or MyChart (only available for patients with an active MyChart account)) and (c) Specific description of records you are disclosing (e.g. only immunization records and lab reports. Note that additional authorization is required for mental health, alcohol/drug use/ developmental disabilities and AIDS/HIV (you must check the appropriate box if you want this information disclosed) and requests for Radiology Films must be directed to another GHC-SCW location.
6. (a) Carefully review your rights regarding this authorization (e.g. your right to revoke); (b) The form must be signed by the authorized individual with legal authority to submit the request. If an individual other than the patient signs the form, the relationship and additional details about the nature of this relationship must be provided; (c) Legal court documentation may be required prior to processing the request and GHC-SCW will act process future requests acting on the most recent document available in the GHC-SCW record; (d) Unless you specifically provide an expiration date, GHC-SCW will release information pertinent to this authorization for a period of one year from the signature date; (e) Provide the signature of authorized individual. (f) Electronic signatures will not be accepted.
7. Submit the completed form to GHC-SCW using one of the following options: (a) Mail the form via USPS to the address provided on this form; (b) Fax the form to the fax number provided on this form; (c) E-Mail the completed form as a PDF attachment to ghcroi@ghcscw.com; (note use of e-mail is considered an unsecured transmission); (d) Drop form off in person at the clinic of your choice or ROI
8. GHC-SCW upholds the patient's right to authorize or deny release of protected health information (PHI) beyond uses for treatment, payment or health care operations.
9. This authorization has been reviewed by GHC-SCW staff that carefully screen what PHI is and is not authorized for disclosure under applicable federal and state laws and regulations and in accordance with the Designated Record Set (Legal Medical Record) Policy. It is integrated into the medical record for permanent storage. Copies are available to the patient upon request.
10. While GHC-SCW acknowledges that disclosure of PHI to plan sponsors and employer groups without certification that the plan sponsor's documents have been amended properly and the necessity to adhere to these and all stipulations of the law, it is our policy to process such requests only for the purpose of enrollment and dis-enrollment transactions or with valid patient consent.
11. GHC-SCW has processes in place to identify, report and improve protections in the event of an impermissible disclosure of PHI.
12. This authorization provides structure for routine use and disclosure of PHI, our use of authorizations, how information is used and accessed with appropriate protections in place for the internal protection of oral, written and electronic PHI.
13. GHC-SCW maintains policies governing the patient's right to access, request restrictions, request amendments, request an accounting of disclosure and the provision and continuing availability of the Notice of Privacy Practices.

Office Use Only

1. Identification:
   - ☐ Driver's License confirmed
   - ☐ Other form of ID confirmed (please specify): _____
2. Confirmation and processing of proper authority, if applicable, verified by:
   - ☐ Power of Attorney for Health Care or Durable Power of Attorney
   - ☐ Legal Guardianship, Custody/Placement Orders, Death Certificate, Emancipated Minor
   - ☐ Other, please specify _____
3. Other steps taken to confirm authenticity of authorization: _____
4. Documentation confirmed may be photocopied and integrated into the GHC-SCW medical record (e.g. driver's license)
5. Specific information disclosed (check all that apply): ☐ CD ☐ Microfilm ☐ Paper ☐ EpicCare ☐ Other: _____

Request Processed By: _____ Date Completed: _____