Marshfield Clinic Health System

Patient Name:	MRN:	DOB:	Sex:

Release of Information Authorization - Occupational Medicine

1. Patient Information	**Name:**	Date of Birth	
	Address		
	City	State	ZIP
2. Health Care Provider or Facility who has the information you want released	**Marshfield Clinic Health System - Occupational Medicine Department**		
	Address		
	City	State	ZIP
	Phone #	Fax #	
3. Where you want the information to be sent or who should be involved in the care	**Name/Organization:**	Attention	
	Phone #	Fax #	
	Address		
	City	State	ZIP

4. Why the information is needed

I understand that the purpose or need for this disclosure is to allow the organization named in Section 3 to:

- ❑ Monitor my occupational health
- ❑ Assure compliance with occupational health and safety regulations and/or company policies
- ❑ Make a determination of whether to hire me or place me in specific employment position

5. What information you want released

***Type of information disclosed:** records, reports, documents, materials, notes, memoranda, correspondence, x-rays, labs. This may include information previous collected about you & contained in the MCHS legal health*

- ❑ Results of pre-placement exam* --- date/date range (m/d/y) _____
- ❑ Results of Department of Transportation exam* --- date/date range (m/d/y) _____
- ❑ Results of surveillance or exposure exam* --- date/date range (m/d/y) _____
- ❑ All office note, audiograms and other work-related test results* --- date/date range (m/d/y) _____
- ❑ Other* --- date/date range (m/d/y) _____

6. When information is needed by

Date information is needed: _____ or Date of the appointment:

7. How would you like this

Release Method / Format Requested: *Note: information applied electronically is in PDF format and is encrypted.*

❑ Mailed ❑ Faxed ❑ USB drive ❑ CD/DVD ❑ Email _____

Other _____

8. Expiration

This authorization is effective for **one year** after the date of signature unless otherwise indicated _____

Patient Signature _____ Date/Time _____ Printed Name _____

Signature of Authorized Person _____ Date/Time _____ Relationship _____

Printed name _____

❑ Parent of Minor ❑ Court appointed guardian/conservator - include legal documentation

Patient Name:	MRN:	DOB:	Sex:

Redisclosure notice to patient: If the person(s) and/or organization(s) listed on the front side are not health care providers, health care clearinghouses, or health plans, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose your health information.

Disclosure notice to recipient of patient health care records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your rights with respect to this authorization

- *Right to receive copy of this authorization* – You have the right to receive a copy of this authorization.
- *Right to refuse to sign this authorization* – You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding:
  – research-related treatment
  – health plan enrollment or eligibility
  – the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party
- *Right to withdraw this authorization* – You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact the Health Information Management (medical records) department. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- *Right to inspect a copy of the health information to be used or disclosed* – You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form. You may arrange to inspect your health information or obtain copies of your health information by contacting the Health Information Management (medical records) department.
- *HIV test results* – Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- *Mental health treatment records* – You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

