**AUTHORIZATION TO VIEW / DISCLOSE HEALTH INFORMATION**

3 R O I

Patient Name _____ MR Number _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____ Phone _____

**I authorize the use or disclosure of the above named patient's Protected Health Information as described below**:

**FROM:**

**MIDWEST ORTHOPEDIC SPECIALTY HOSPITAL**

**OTHER:**

_____

_____

**TO:**

Name _____

Address _____

City _____ State _____

Zip _____

Fax Number _____

**FOR THE PURPOSE OF:** (Check all that apply.)

☐ View Protected Health Information ONLY: Date_____ Time_____

☐ Continued Care ☐ Legal ☐ Insurance ☐ At Request of Patient ☐ Other _____

**INFORMATION TO BE VIEWED AND OR DISCLOSED:**

**Date(s) of Service:** _____ **to** _____ **or Type:** _____

☐ Record Abstract ☐ Discharge Summary ☐ History & Physical ☐ Operative Record ☐ Lab Results

☐ X-ray Reports ☐ Emergency Record ☐ HIV/AIDS (including test results) ☐ Substance Abuse Record

☐ Mental Health Treatment Records ☐ Immunization Record

☐ Other _____

I understand that the information in my health record may include information relating to mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
I understand that if I refuse to authorize the disclosure of this information, the information may not be released.

I further understand that HIV test results may be disclosed without my permission in certain circumstances and that a list of such circumstances is available to me upon request.

I further understand that I have a right to inspect or receive a copy of any health information used or disclosed.
I understand that if I sign this authorization, I will be provided with a copy of this authorization upon request.

In support of your privacy, Midwest Orthopedic Specialty Hospital does not accept your blanket authorization to disclose Protected Health Information
of treatment you have not yet received. A new authorization will be required for each new episode of care.

midwest orthopedic
SPECIALTY HOSPITAL
10101 S. 27th Street
Franklin, WI 53132

**Authorization To View / Disclose Health Information For Hospitals**

109763 07/2009
79466 04/2009 R3

PATIENT LABELS MUST BE PLACED HERE ON ALL PAGES (PARTS) – SIDES OR FOLD-OUT (PANELS) THAT THIS BOX APPEARS ON.

I understand that I have a right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the Health Information Department. I understand that my revocation will not apply to information that has already been released in response to this authorization.

I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected by such laws.

This authorization expires 365 days from the date it is signed by the patient unless otherwise noted _____.

This authorization is voluntary. Midwest Orthopedic Specialty Hospital will not condition your treatment on this authorization.

_____ _____ _____

Signature of Patient or Authorized Representative | Date | Time

(If you are signing as a parent of the minor patient listed above, you are declaring that you have not been denied physical placement and/or parental rights of the child because such placement would endanger the child's physical, mental, or emotional health.)

**If signed by other than patient, indicate relationship or authority:**

Patient is: ☐ a Minor ☐ Incompetent ☐ Deceased

I am: ☐ Parent ☐ Legal Guardian ☐ Next of Kin of Deceased ☐ Executor of Estate

☐ POA for health care (activated)

_____ _____ _____

Signature of Witness | Date | Time

If unable to sign document, give reason _____

NOTE: "This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

**OFFICE USE RELEASE LOG**

Identification Verified: _____ (initials) Signature Verified: _____ (initials) Date: _____ Time: _____

Route of Release: ☐ Fax ☐ Mail ☐ Pick-up ☐ Patient notified of applicable fees

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