



## **NEUROLOGIC ASSOCIATES OF WAUKESHA MEDICAL RECORDS RELEASE REQUESTS**

Neurologic Associates wants to assist you in getting your medical records to other healthcare providers when you need them. Neurologic Associates of Waukesha Medical Records Department will process a release request from our office to another healthcare provider, free of any charge to you, with the attached signed authorization or a faxed request from your doctor's office requesting your medical records.

It is important to us that you understand the process for requesting your medical records and the requirements around releasing those records. We have attached our authorization form for requesting any release of your medical records. A fee schedule pertaining to the release of your records is included on the back side of this informational sheet. Please read the forms carefully.

All completed release forms should be submitted to the Neurologic Associates of Waukesha Medical Records department at 1111 Delafield Street, Suite 105, Attn: Medical Records, Waukesha, WI 53188 or Faxed to 262-522-7286.

### **FEES FOR RECORDS**

Neurologic Associates of Waukesha uses CIOX Health to process and fulfill all other requests for copy or release of your medical record. CIOX Health charges a reasonable fee for, copying, postage and preparation of records to fulfill this request. All fees are based on the applicable laws governing release of Health information. CIOX Health will process your records within 3 to 10 business day of receiving the completed release request form. Please see the CIOX Health document on the back of this page. CIOX Health may release up to 5 pages free of charge. CIOX Health Customer Service: 1-800-367-1500

You may call our Medical Records Department at 262-522-7840 with any questions regarding your request or these forms.

Thank you for allowing Neurologic Associates of Waukesha to be part of your healthcare team.

# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

**PATIENT INFORMATION:**

Name of Patient/Previous Names \_\_\_\_\_ Birth Date \_\_\_\_\_ Medical Record Number \_\_\_\_\_  
Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

**AUTHORIZES DISCLOSURE BY:**

- PHC, Oconomowoc Memorial Hospital  
 PHC, Waukesha Memorial Hospital  
 PHC, Behavioral Medicine Center  
 PHCMA – Clinic/Provider \_\_\_\_\_  
 ProHealth Solutions Participant \_\_\_\_\_  
 Other: \_\_\_\_\_

**DISCLOSURE OF HEALTH INFORMATION TO:**

Name of Health Care Provider/Plan/Other \_\_\_\_\_  
Street Address \_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_

**INFORMATION TO BE DISCLOSED:** Identify below the specific information you are authorizing to be disclosed:

- Billing Records     Discharge Summary     History & Physical     Consultation     Operative Report     ED Report  
 Pathology Report     Radiology Report     Radiology Films     Laboratory Report     Rehab Notes  
 Progress Notes     Other: \_\_\_\_\_

**DISCLOSURES REQUIRING SPECIAL CONSENT:** In compliance with Wisconsin Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply.

- HIV/AIDS\*     Mental/Behavioral Health Conditions     Drug/Alcohol Abuse/Treatment     SANE     SANE Photos

**FOR THE FOLLOWING DATES:** From: \_\_\_\_\_ To: \_\_\_\_\_

**PURPOSE FOR DISCLOSURE:** Please provide specific purpose for disclosure or check applicable category.

- Continuing Care     Transfer to New Provider     Insurance/Claim Purposes     Legal     Personal Use  
 Disability Determination     Workers Compensation     Vocational Rehab Eval

Other: \_\_\_\_\_

Check One:  Verbal Release     Paper Release     Electronic/Digital Release (specify) \_\_\_\_\_

Release by:  US Mail     Fax \_\_\_\_\_     Pick-Up: Location \_\_\_\_\_

**YOUR RIGHTS WITH RESPECT TO 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 (may be provided at a reasonable fee) of the health information I have authorized to be used or disclosed by this authorization form. **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, I may receive a copy. **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form and that ProHealth Solutions Participant may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. **Right to Withdraw This Authorization** – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to ProHealth Care's Release of Information Department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organizations(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. **\*HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State laws and a list of those persons/organizations is available upon request. **\*\* WI Statutes 51.30 and 252.15** requires patient authorization to disclose health information for payment purposes. **Copy or Facsimile (FAX) Valid as an Original.**

This information has been disclosed to you from records protected by Federal (42 CFR Part 2) and Wisconsin (51.30) confidentiality rules. 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.

**EXPIRATION DATE:** This authorization is good until the following date(s) \_\_\_\_\_ or 6 months from the date signed.

**SIGNATURE OF PATIENT/LEGAL REP:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**Information Released By:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_