ThedaCare™

Authorization for the Disclosure of Health Information

Photocopy or facsimile of the original authorization will be considered as valid as the original

Patient:

Patient name/previous names associated with patient

Date of birth or Medical Record number

Patient phone number

Street address

City/state/ZIP

Authorizes: (Information to be released from)

ThedaCare, Inc. Medical Records
Name of health care provider

122 E. College Avenue
Street address

Appleton, WI 54911
City/state/ZIP

Information released to:

Heart and Vascular Institute of Wisconsin
Name of receiver

5045 W. Grande Market Drive
Street address

Appleton, WI 54913
City/state/ZIP

Information to be released includes:

- ❑ Immunizations
- ❑ Discharge summ
- ❑ History and physical
- ❑ Consultations
- ❑ Operative reports
- ❑ ER Reports dates/type: _____
- ❑ X-ray reports (dates/type): _____
- ❑ Lab reports (dates/type): _____
- ❑ HIV tests
- ❑ Electrocardiogram (EKG)
- ❑ Cardiac cath. reports
- ❑ PT/OT/speech therapy notes
- ❑ Rehab clinic reports
- ❑ Occup. health clinic records
- ❑ Mental health records
- ❑ Alcohol and drug abuse records
- ❑ Fit for work records
- ❑ Doctors orders and progress notes: dates/type: _____
- ❑ Clinic visit: dates: _____
- ❑ Copies of reports originating from other providers: be specific: _____
- ❑ Other: _____
- ☒ Request release of original clinic record in its entirety moved to: Heart and Vascular Institute of Wisconsin
  (Applies to ThedaCare clincs only—not for any other use)

Need for the disclosure:

- ❑ Changing physicians/relocation/moving
- ❑ Disability determination
- ❑ Legal investigation
- ❑ Vocational rehab evaluation
- ❑ Court case
- ❑ Consultation/further medical care
- ❑ Worker's Comp injury
- ❑ Personal (if acting as a personal representative of the patient, please state purpose of how you are acting on behalf of the patient): _____
- ❑ Payment process/insurance/billing difficulties
- ❑ Application insurance
- ☒ Other: My cardiology provider is relocating to Heart and Vascular Institute of Wisconsin and I want my medical records transferred there.

I understand that if the person(s) and/or organization listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Your rights with respect to this authorization

Right to Inspect or Copy the Health Information to be used or disclosed—I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department. **Right to Receive Copy of this Authorization**—I understand that if I agree to sign this authorization, which I am not required to do so, I must be provided with 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 health care benefits on my decision to sign this authorization. Right to Withdraw this Authorization—I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health 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 organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) April 1, 2020 or for one year from the date signed. I have had opportunity to review and understand the content of this authorization form. By signing this authorization I am confirming that it accurately reflects my wishes.

Signature of Patient/Legal Representative: _____

Date: _____ (If signed by other than the patient, state relationship and authority in which to sign for the patient, i.e. deceased, minor, incompetent)

Request filled by: _____ (Employee) Date: _____ Records Released: _____