



# 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: \_\_\_\_\_
- 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 clinics only—not for any other use)
- 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

### Need for the disclosure:

- Changing physicians/relocation/moving
- Disability determination
- Legal investigation
- Personal (if acting as a personal representative of the patient, please state purpose of how you are acting on behalf of the patient): \_\_\_\_\_
- Vocational rehab evaluation
- Court case
- Consultation/further medical care
- Worker's Comp injury
- 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: \_\_\_\_\_