Aurora Health Care® *Milwaukee, Wisconsin*

MRN / Chart #: _____

1) **PATIENT INFORMATION:**

_____
Name Address City State Zip

_____ (_____)_____ _____
Date of Birth Daytime Phone Previous Name

2) **AUTHORIZES:**

AURORA SHEBOYGAN MEMORIAL MEDICAL CENTER
Name of Health Care Provider / Plan / Other

2629 NORTH 7TH STREET, SHEBOYGAN, WI 53083
Address

3) **TO DISCLOSE TO:**

☐ Self, Delivery Options: ☐ Pick up: ☐ View on Site ☐ Mail to address above

☐ To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

Send to: ■ RECORDS DEPOSITION SERVICE, INC.
Name of Health Care Provider / Plan / Other

120 W. MADISON STREET, SUITE 300, CHICAGO, IL 60602 P: 312-553-8900 F: 312-553-8901
Address Or Health Care Provider FAX #

4) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From _____ (month/year) to _____ (month/year) **If left blank, only information from the past two (2) years will be disclosed.**

5) **INFORMATION TO BE DISCLOSED:**

☐ All medical records related to (specify condition, treatment, etc.): _____

☐ All billing records related to (specify condition, treatment, etc.): _____

☐ Radiology films/images (specify test): _____

■ Specific records/information as follows: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):

☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health / Developmental Disabilities

6) **EXPIRATION:** This Authorization is good until the following date / event: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) **PURPOSE** (Check all that apply - **copy fees may apply**) ☐ Further Medical Care ■ Legal Investigation /Action
☐ Insurance Eligibility/Benefits ☐ Personal (at my request) ☐ Other: _____

8) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) **SIGNATURE OF PATIENT / LEGAL REP:** _____ **DATE:** _____
If signed by a person other than the patient, complete the following:
1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin / executor of deceased ☐ activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only:
Signature/ID verified ☐ Yes ☐ No Completed by: _____ # of pages released _____
Name / Date

* S 2 3 6 2 3 *

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION (Pre Tab / Corres)

White – **Medical Record** / Yellow - **Patient**
 (Rev. 01/11)