FOR CLINIC USE ONLY

Beloit Health System

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PLEASE NOTE:
The name of the individual picking up medical records must be listed on the authorization. No one other than those listed will be granted access, including spouses.

Name of Patient: _____ Date of Birth: _____

Address of Patient: _____ Phone #: _____

_____

I hereby authorize and request:	To disclose to: **(ex: self, spouse, Dr., etc)**
_____	**RECORDS DEPOSITION SERVICE, INC.**
_____	**120 W. MADISON STREET, STE. 300**
_____	**CHICAGO, IL 60602**
_____	**P: 312-553-8900 F: 312-553-8901**

(Name, address and phone number of individual, agency or organization)

Service Dates to be released: From _____ to _____
Specific information requested:

____ Discharge Summary	____ History & Physical	____ Consultations
____ Radiology Reports	____ Radiology Films/Images	____ HIV Test Results
____ Pathology Reports	____ Operative/Procedure Reports	____ Mental Health
____ Lab Reports	____ Diagnostic Studies	____ Drug/Alcohol
____ Clinic Note	____ Emergency Dept Record	Abuse/Treatment

__X__ Other: **Please see enclosed Subpoena or Letter Request for information to be disclosed.**

❑ Request records on electronic media

The purpose of this disclosure:
____ Continued Medical Care ____ Legal ____ Personal ____ Insurance
__X__ Other (Specify): **For Discovery Before Trial**

I understand that I have the right to copy and inspect the information which is to be released. I further understand that the records contain information regarding the patient's medical condition and treatment and possibly could include information pertaining to drug and/or alcohol usage and/or mental health status and/or AIDS or HIV related illness.

It is further understood that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and submit this statement to Medical Records/Health Information Management at Beloit Health System. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date or event: _____ .
If I fail to specify an expiration date, this authorization will expire in six months. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may not be protected by federal confidentiality rules.

I understand that I am under no obligation to sign this form, and that Beloit Health System may not condition treatment or payment on my decision to sign this authorization except for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____
(Signature of patient or person authorizing consent) (Date)

_____
(Relationship, if other than patient)

Beloit Memorial Hospital
1969 W Hart Rd
Beloit, WI 53511-2230
(608) 364-5011

Beloit Clinic
1905 E. Huebbe Pkwy
Beloit, WI 53511-1842
(608) 364-2200

Clinton Clinic
307 Ogden Ave
Clinton, WI 53525-9007
(608) 676-2206

Darien Clinic
300 N. Walworth
Darien, WI 53114-1534
(262) 882-1151

Janesville Clinic
1321 Creston Park
Janesville, WI 53545-1126
(608) 757-1217

NorthPointe Campus
5605 E. Rockton Road
Roscoe, IL 61073-7601
(815) 525-4500

Occupational Health, Sports and Family Medicine Center
1650 Lee Lane
Beloit, WI 53511-3935
(608) 364-4666

West Side Clinic
1735 Madison Road
Beloit, WI 53511-3216
(608) 363-7510

ADDITIONAL INFORMATION REGARDING RELEASE OF PATIENT INFORMATION

Beloit Health Systems recognizes the patient's right to confidentiality of medical records as in the Illinois and Wisconsin Statutes. Therefore, you should be aware of the following guidelines when requesting medical records.

Both Illinois and Wisconsin Statutes recognize the need for informed consent. The patient may request multiple releases of the information stated on the authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's signature. A new authorization is necessary for release of information on care provided after the date of your signature, UNLESS it is the authorization to release "future records of a specific test, specified clinic appointment and/or admission with the month and year identified."

All patients 18 years of age and over must sign for release of their own medical records unless the following conditions apply:

* The patient is incompetent.
* The patient is disabled and cannot sign the form.
* The patient is deceased. (The surviving spouse or legal representative must sign authorization releasing records of the deceased person.)

Patients less than 18 years of age must sign for release of the medical records when:

* The patient is 14 years of age or older and the records involve treatment for mental illness, alcoholism, or drug dependency.
* The patient's records for release include abortion.

All persons signing for release of records, instead of the patient, must state their relationship to the patient and have available proof of legal authority to release the records.

For continuation of care, pertinent portions of your medical information will be sent to your physician/medical facility free of charge. All other requests are subject to fees. Some record requests may require pre-payment. If your request requires pre-payment an invoice will be sent to you with instructions on how to submit payments. If payment is required, the records will be sent after the payment is received.

If you have any questions regarding the above information, please do not hesitate to ask us.