

Meriter Hospital and Clinics
Mail to:
Health Information Management
202 S. Park Street
Madison, WI 53715 (608) 417-6406

Date released: _____
Released by: _____
Pages: _____

1. Patient Name: _____
Date of Birth: _____ Phone: _____
Previous name (s): _____
Address: _____
(Street Address) (City) (State) (Zip Code)

I authorize the use and/or release of my protected health information as described in paragraph four (4) below.

2. AUTHORIZE:

(Name of person or organization) (i.e.: Meriter Hospital and Clinics)

(Street Address)

(City, State, Zip Code)

3. RELEASE PROTECTED HEALTH INFORMATION TO:

(if release is to Self, State Self):
RECORDS DEPOSITION SERVICE, INC.

(Name of person or organization you want information released to)
PO BOX 5054

(Street Address)
SOUTHFIELD, MI, 48086-5054

(City, State, Zip Code)

4. PURPOSE OR NEED OF DISCLOSURE: (Check all that applies)

- | | | |
|---|--|---|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Social Security Disability | <input type="checkbox"/> Application for Insurance |
| <input type="checkbox"/> Legal Investigation or Action | <input type="checkbox"/> Obtain Payment for Insurance Claims | <input type="checkbox"/> Patient's Request (Personal Use) |
| <input type="checkbox"/> Vocational Rehabilitation Evaluation | <input type="checkbox"/> Continuity of Care Document (CCD) | <input checked="" type="checkbox"/> Other (Specify): <u>PRE TRIAL DISCOVERY</u> |

I understand that if the person(s) and/or organization(s) 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.

5. TYPE OF INFORMATION TO BE DISCLOSED: (complete a. through d.)

- a. Records regarding type of treatment: _____
b. Records from the time period: _____
c. Records of related treatment that occurs after the date of my signature may / may not be released.
d. Specific information requested: (please specify below)
- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Discharge Summary* | <input type="checkbox"/> Cardiac Testing | <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> All Pertinent Information (see *) |
| <input type="checkbox"/> History and Physical* | <input type="checkbox"/> Consultations | <input type="checkbox"/> Therapy Notes (OT, PT, Speech) | <input type="checkbox"/> Operative/Pathology Reports* |
| <input type="checkbox"/> X-ray* <input type="checkbox"/> Lab* | <input type="checkbox"/> Anesthesia Records | <input type="checkbox"/> Medication List | |
| <input type="checkbox"/> Continuity Care Document | <input checked="" type="checkbox"/> Other (Specify): <u>PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST</u> | | |

The information to be released may include psychiatric, developmental disability, alcohol abuse, drug abuse, HIV test results, AIDS or AIDS related disease diagnosis unless specified: _____

6. EXPIRATION DATE: This authorization shall be valid for one year unless otherwise stated or revoked through written notice to the Health Information Management Department. Alternate date or event if not one year _____

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 Management Department. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization. I have a right to receive 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 or payment on my decision to sign this authorization. **Right to Revoke This Authorization** - I understand that I may revoke this authorization in writing at any time. To obtain information on how to revoke my authorization or to receive a copy of my revocation, I may contact the Health Information Management Department. I am aware that my revocation 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.

7. SIGNATURE OF PATIENT: _____ **DATE SIGNED:** _____

8. SIGNATURE OF AUTHORIZED PERSON (If applicable): _____ **DATE SIGNED:** _____

If signed by other than patient, state relationship and authority to do so.

Legal Authority: Legal Guardian (Attach court action) Next of Kin (Spouse, if living) Power of Attorney(Attach POA for Health Care papers)
 Parent of Minor *Proper legal documentation must be on file.





Acknowledgement of Medical Record Request Processing Fee

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows a fee (whether regulatory or statutory) to be associated with medical record request processing, excluding those that are needed for continuing care purposes.

Meriter has partnered with HealthPort Technologies, LLC to process and fulfill your request for a copy of your medical record. The regulated fee in the State of Wisconsin is detailed below:

Detail of State Rates:

\$1.04 per page for pages 1-25
\$0.77 per page for pages 26-50
\$0.52 per page for pages 51-100
\$0.31 per page thereafter

Microfilm - \$1.55 per page

Plus tax and postage

By signing below, I acknowledge that I am aware of the fee that will be billed to me for requesting a copy of my medical record. I agree to pay this fee when services are rendered and I receive an invoice from HealthPort Technologies.

Name: _____ Phone #: _____

Address: _____
Street City State Zip

Patient Signature: _____ Date: _____
(or authorized representative)

Email address for electronic delivery request for medical record: _____

The fee should be remitted to HealthPort Technologies as directed on the HealthPort invoice you receive. Please note that there is no fee for medical record requests sent directly to a physician or healthcare facility for continuing care purposes.

HealthPort Technologies, Inc. Release of Information Processing Center
120 Bluegrass Valley Parkway Alpharetta, GA 30005
Customer Service: 800-367-1500
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Madison, Wisconsin

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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