BAYCARE CLINIC

RELEASE OF INFORMATION and AUTHORIZATION TO DISCLOSE – WRITTEN RECORDS

Medical Records related to care provided in a hospital or surgery center, such as Emergency Department or Anesthesia services at a facility, are maintained by and can be obtained from the facility where the service was provided. ***BayCare Clinic records can be requested & received at no charge via MyBayCare portal: https://my.baycare.net/BaycareClinicsMyChart/***

Please complete sections 1-8. If you have questions about this form please call 920-544-5414.

1. Patient Name_____ Date of Birth:____/____/_____

Address_____ Last 4 of SSN: _____

City, State, Zip Code_____ Phone #: (_____) _____

2. Records **From (Select 1)**:

☐ BayCare Clinic (Specify ALL Providers/Departments or List individual Providers/Departments_____

☐ Other Provider/Office/Facility_____Address: _____

City, State, Zip Code_____ Phone: _____ Fax: _____

3. Records **To (Select 1)**:

☐ BayCare Clinic (Specify Providers/Departments)_____

■ Other Provider/Office/Facility RECORDS DEPOSITION SERVICE, INC. Address: PO BOX 5054

City, State, Zip Code SOUTHFIELD, MI, 48086-5054 Phone: 248-357-3330 Fax: 248-357-3337

4. INFORMATION TO DISCLOSE

☐ Medical Records AND/OR ☐ Billing Info

Dates: From_____to_____

☐ Office Notes ☐ X-Ray Reports

☐ Lab ☐ All

☐ BayCare Clinic Radiology Images (Specify Images for CD):_____

☐ Other PLEASE SEE ATTACHED REQUEST

5. DELIVERY METHOD

☐ Online – MyBayCare (No fee)

☐ Mail (Fee may apply)

■ Fax to 248-357-3337 (Fee may apply)

☐ Pickup Records(Fee may apply)

☐ Digital (CD)(Fee may apply)

6. PURPOSE FOR DISCLOSURE

☐ Legal

☐ Insurance

☐ Personal

☐ Continuing Care

☐ Other: _____

CHECK BOXES BELOW TO ALLOW FOR DISCLOSURE OF THE FOLLOWING :

☐Mental Health Treatment Records ☐Substance Use Disorder Treatment Records ☐Developmental Disability Treatment Records ☐HIV Status

7. This Authorization is valid until date/event: _____but in no case longer than one year from signature.

I understand that:

- I can revoke this consent in writing, which will be effective upon receipt by BayCare Clinic Release of Information Department.
- BayCare Clinic may disclose information to additional entities upon receiving verbal or written consent from me.
- Completion and signing of this form authorizes the release of information to the entities above; this means that should that entity re-disclose my protected health information, the information may no longer be protected within the guidelines of federal privacy standards.
- I have a right, upon written request, to inspect the materials disclosed and that this inspection is at no cost to me and will be in the presence of a BayCare Clinic employee.
- I can receive a copy of the materials disclosed as required under ss.HSS.92.05 and 92.06 and that associated copying fees are charged in accordance with Wisconsin Statutes.
- Information relating to my treatment may be released upon my agreement or as otherwise specified by 42 CFR, 45 CFR 164.508 and Wisconsin State Statutes 51.30, 146.025 and 146.81.
- My signature on this form is not required for me to receive treatment; a copy shall be provided to the patient upon request.
- I have read and understand the contents of this form.

_____ _____

8. Signature of Patient or Representative Date Printed Name / Relationship of Representative to Patient