Mail to: DIME Medical
340 Main Street
Darlington, WI 53530
Fax to: (855) 574-5406 **Phone:** (608) 482-2005

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Information:

Name:		Birthdate:
Address:		Telephone:
City:	State:	Zip Code:

Released from: ☐ **DIME Medical** **(or fill in below)**

Released to: ☐ **Patient listed above** ☐ **DIME Medical** **(or- fill in below)**

Name-(e.g. Health Facility, Physician)		**Name-(e.g. Insurance, Lawyer, Physician, Patient)**	
Address		**Address**	
City, State, Zip		**City, State, Zip**	
Phone	**Fax**	**Phone**	**Fax**

***Date of upcoming appointment (if applicable)*: ____________________** **Pick up date: ______________**

_____Paper _____Electronic Format Visit Dates to be released: ______________________________

Type or extent of information to be released: (Check all that apply)

_____All Records (except) ____History/Physical Exams ____Progress Notes ____ER Record
_____Discharge Summary _____Xray Reports _____Xray Films/CD ____Occup. Therapy
_____Laboratory Reports _____Procedure/Pathology Reports ____Electrocardiogram ____Physical Therapy
_____Immunizations _____Allergy Records _____Prescriptions ____Speech Therapy
_____Account information (patient name/address, responsible party name/ address, ins.co. name, policy number) ____Condition to media
_____Other: ____

According to Wisconsin State Statutes, the categories listed below require special permission for release. Please indicate for any of the following items that you wish to be released instead of or in addition to the items indicated above.

____Mental Health ____Developmental Disabilities ____Alcohol/ Drug Records
____HIV Test Results ____HIV Treatment records ____Sexually Transmitted Disease Test Results and Treatment Records

Purpose or need for release: (Check all that apply)
Note: There may be a charge for copies of Medical Records for purposes other than further medical care.

_____Further medical care _____Application for insurance ____Personal ____Law Enforcement
_____Payment of insurance claim _____Disability determination ____Legal ____Inspection
_____Medical Equipment/ Supplies ____Ambulance Service ____Media Release
_____Other: ____

THIS SPACE For staff use only:

Date released or sent:____________________
Method of transfer:______________________

____TURN PAGE OVER to continue form.

- I understand that if the person(s) and/or organization(s) listed above as the recipients of my protected health information are not health care providers or health plans (health insurance companies) that the information I am authorizing the release of may no longer be protected by the federal or state privacy standards and my health information may be re-disclosed without obtaining my authorization.**
- I will hold harmless DIME Medical / Divine Mercy Medical Clinic, LLC from and against any and all liability in connection with the disclosure of protected health information as authorized herein.
- I understand I may inspect and arrange for photocopies of the information that will be disclosed as a result of this authorization.
- This authorization will remain in effect to carry out the purpose for which it is intended, but will not remain in effect for dates of medical service beyond the stated expiration date.
- I understand that I may revoke this authorization at any time (except to the extent action has already been taken in good faith reliance on this authorization) by submitting a written request to DIME Medical.
- I understand that my medical information to be disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal Law
- If I refuse to sign this authorization, my medical records/ information will not be released.

I am requesting my medical information be sent to me by email at: ____.
I understand that email transmission is **not secure** and there is a chance that my information could be breached. Knowing these risks, I would like to receive my information by email.

____ ________________________
Signature of Patient (must be 18 years of age or older) **Date**

____ ________________________
Signature of Authorized Person (Relationship) **Date**

____ ________________________
Signature of Witness **Date**

This authorization will expire on the following date:_____________________. I understand if I do not specify an expiration date, the authorization will expire in one year.
**Please note that regardless of expiration date, information will only be released for dates of medical service performed on or before the date of the signature of the patient or authorized person.*

Relationship of Authorized Person Signature:

___Custodial Parent ___Legal Guardian ___Executor of Estate of Deceased

___Power of Attorney for Healthcare* ___Authorized Legal Representative* ___Court Appointed Temporary Guardian

Patient is: ___Minor ___Incompetent ___Disabled ___Deceased ___Incapacitated

***Must have written proof that representative is Power of Attorney for Healthcare or Authorized Legal Representative and the document must state that the Authorized Person may obtain and / or sign for legal papers and/ or medical information. The patient must be legally incapacitated in order for the Power of Attorney for Healthcare to sign in place of the patient.**

**** Exception: Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) indicate that those records are protected and cannot be disclosed or re-disclosed without the individual patient's written consent unless otherwise provided for in the regulations.**

NOTICE TO RECIPIENT OF INFORMATION: This notice may accompany a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal Confidentiality rules 42 CFR Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient RIGHTS:

- ❖ **Right to Inspect or Copy the 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.
- ❖ **Right to Receive Copy of This Authorization.** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy.
- ❖ **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 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 DIME Medical. I am aware that my withdrawal will not be effective for uses or disclosures made previous to my withdrawal.

A COPY OF THIS FORM IS AS VALID AS THE ORIGINAL.