OAKLEAF SURGICAL HOSPITAL

ROI

REQUEST/ AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

_____ _____ _____

Patient Name/Previous Name(s) Date of Birth Phone Number

_____

Street Address, City, State, Zip Code

RELEASE INFORMATION FROM: OakLeaf Surgical Hospital- 1000 OakLeaf Way, Altoona, WI 54720

Phone: 715.831.8130 ROI Fax: 715.952.0972

RELEASE INFORMATION TO:

☐Self: **Delivery Options**: ☐Pick Up ☐Mail to address above ☐Fax_____☐Email_____

Format: ☐Paper ☐ Electronic Media

☐Send to Individual/ Healthcare Facility/Other:

Name: _____

Street Address _____

City, State, Zip Code _____

Phone: _____ Fax: _____

INFORMATION TO BE DISCLOSED: ☐**Written** ☐**Verbal.**

Date(s) of Service: _____ (If left blank only information from last 2 years will be disclosed)

___Operative Reports ___ Discharge Summary ___ Pathology Reports ___ Abstract (D/S Summary, H&P, Consult, Path, Operative Report, Lab, Radiology)
___ History & Physical ___ Radiology Reports ___ Progress Notes ___Other _____
___ Consultations ___ Radiology Images/CD ___ Laboratory Reports

In compliance with Wisconsin Statutes, to release privileged information, please release records pertaining to:

___Mental Health ___Developmental Disabilities ___Alcoholism
___HIV (AIDS) ___Sexually Transmitted Disease ___Drug Abuse

PURPOSE OF DISCLOSURE:

___Continuation of Care ___Legal Investigation ___Insurance Benefits ___Personal

We may be prohibited from making certain information available to you or to your representative, including:
Psychotherapy, Information related to medical research in which you have agreed to participate, Information related to legal proceedings, Information obtained under a promise of confidentiality, Information that federal or state laws prevent us from disclosing, Information for which the disclosure may result in harm or injury to your or to another person, Information related to certain lab results subject to CLIA.

YOUR RIGHTS WITH RESPECT TO THIS REQUEST:

Within the limitations of the law, we will make every effort to accommodate your request. We will complete our review of your request and as requested either provide a copy or arrange for you to inspect your records within 30 days of your request or provide you with a written explanation of any restriction on the information that we can provide you. The organization 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. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to Oakleaf Surgical Hospital. I understand 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.

EXPIRATION: This Authorization is good until the following date/event: _____
Or if this item is left blank, the authorization will expire in 1 year from the date signed.

_____ _____

Signature of Patient or Legal Representative/Relationship Date

_____

Printed Name of Patient

Revised 05.01.2023.

Staff Use: Staff Initials_____ ☐ROI Send Records ☐Scan to Chart