PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

*(Complete in full. See reverse side for important information.)

Dean HEALTH SYSTEM

1. _____, _____
(name of patient) (birthdate)

_____ _____
(street address) (city, state, zip code)

I authorize the use and/or release of my protected health information as described in paragraph 4 below. I understand this authorization is voluntary and is made to confirm my instructions.

I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization.

2. AUTHORIZE:

DEAN CLINIC WEST
752 N HIGHPOINT ROAD
MADISON WI 53717

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:
(If release is to Self, state Self)

ExamOne
800 NW Chipman Rd. / Suite 5900
POBox 2340
Lee's Summit, MO 64063-1149
Toll Free 888-521-2004 (FAX: 800-997-2771)

4. HEALTH INFORMATION TO BE RELEASED:

_____ All Medical Records
_____ Immunization Records
_____ Lab Reports
_____ X-ray Reports
_____ X-ray Films - Specify
_____ Billing Records - Specify

_____ Other (for any other information please give a meaningful description or explanation)
_____
_____
_____

FOR THE FOLLOWING DATES: _____

4a. In compliance with Wisconsin Statutes which require special permission to release otherwise privileged information, please release records pertaining to:

X Mental Health
X Alcoholism
X HIV (AIDS)
X Developmental Disabilities
X Drug Abuse
_____ Other _____

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

_____ further medical care
_____ insurance eligibility/benefits
_____ disability determination
_____ at the request of the patient
_____ vocational rehabilitation evaluation
_____ Other _____
_____ legal investigation

6. EXPIRATION
This authorization will expire on _____/_____/_____ (DD/MM/YYYY). If I do not indicate a date, this will expire one (1) year from the date of my signature below.

7. SIGNATURE.
I have had full opportunity to read and consider the contents of this Authorization, and I confirm that the contents are consistent with my direction to the health care provider. I understand that, by signing this form, I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this Authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
SEE REVERSE SIDE FOR IMPORTANT INFORMATION

ADDITIONAL INFORMATION REGARDING RELEASE OF HEALTH INFORMATION

Dean Health System recognizes the patient's right of confidentiality of their health information under federal privacy regulations and Wisconsin law. The patient should be aware of the following information when requesting or releasing health information.

- **Right to Refuse to Sign This Authorization:** A patient may refuse to sign this Authorization and this refusal will not affect the patient's ability to obtain treatment or payment of claims.
- **Right to Inspect or Copy the Health Information to Be Used or Disclosed:** A patient has the right to inspect or copy the health information they have authorized to be used or disclosed by signing this Authorization form. A patient may arrange to inspect their health information by contacting the office listed below.
- **Right to Receive Copy of This Authorization:** A patient has the right to receive a copy of the signed Authorization form.
- **Right to Revoke This Authorization:** A patient has the right to revoke this Authorization at any time by giving written notice of revocation to the Privacy Officer listed below. Revocation of this Authorization **will not** affect any action taken in reliance of this authorization before receipt of the written notice of revocation.
- **Multiple Releases of Information:** A 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 for care provided after the date of the patient's signature, unless the Authorization specifically states that specific records that will be generated in the future may be released, for example "future records of a specific test" or " future records of specific clinic appointment."
- **Who May Sign This Authorization:**
  1. Generally, all patients 18 years of age and older must sign for release of their own health information unless the following conditions apply:
     a. The patient is incompetent
     b. The patient is disabled and cannot sign the form
     c. The patient is deceased. (A surviving spouse or personal representative of the estate may sign. If there is no surviving spouse or personal representative, then an adult member of the immediate family may sign.)
  2. All persons signing for release of health information on behalf of the patient must state their relationship to the patient and provide proof of legal authority of their capacity to act for the patient.
  3. Minors: Patients less than 18 years of age must sign for release of their health information in the following cases:
     a. Alcohol or other drug abuse treatment: age 12 or older
     b. Mental health treatment: age 14 or older may consent to release of records without parental consent (Parents also retain the right to access this information.)
     c. HIV test results: age 14 or older
     d. Emancipated minors who are married or in the military
- **Fees for Records:** Dean Health Systems may charge a reasonable fee for viewing, copying, postage and preparation of records to fulfill this request. All fees are based on the applicable laws governing release of health information.
- **Contact Office:**
  1. Requests for **release of health information** can be directed to the Medical Records Department or other appropriate department at the site where the services were provided or you may call our main office at **608/252-8275**.
  2. All **questions regarding federal privacy regulations** can be directed to:
     DHS Privacy Officer: 1808 West Beltline Highway, Madison, WI 53713
     Telephone: 608 / 250-1075, E-Mail: PrivacyOfficer@deancare.com