HIM ROI Authorization

UnityPoint Health Meriter | PARTNER OF UWHealth

UnityPoint Health-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:

_____
(Name of person or organization you want information released to)

_____
(Street Address)

_____
(City, State, Zip Code)

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

☐ Further Medical Care ☐ Social Security Disability ☐ Application for Insurance
☐ Legal Investigation or Action ☐ Obtain Payment for Insurance Claims ☐ Patient's Request (Personal Use)
☐ Vocational Rehabilitation Evaluation ☐ Continuity of Care Document (CDC) ☐ Other (Specify): _____

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)**

☐ Discharge Summary* ☐ Cardiac Testing ☐ Emergency Room Record ☐ All Pertinent Information (see *)
☐ History and Physical* ☐ Consultations ☐ Therapy Notes (OT, PT, Speech) ☐ Operative/Pathology Reports*
☐ X-ray* ☐ Lab* ☐ Anesthesia Records ☐ Medication List ☐ Continuity Care Document
☐ Other (Specify): _____

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.

PATIENT LABEL

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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Rev.08/2020