Aurora Health Care• Milwaukee, Wisconsin

MRN / Chart #: _____

1) **PATIENT INFORMATION:**

_____
Name Address City State Zip

_____ (_____)_____ _____
Date of Birth Daytime Phone Previous Name

2) **AUTHORIZES:** **Aurora Health Care – Provider:** _____

Name of Health Care Provider / Plan / Other

Address

3) **TO DISCLOSE TO:** ☐ Self, Delivery Options: ☐ Pick up ☐ View on Site ☐ Mail to address above ☐ Electronic Format: _____

☐ To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

☐ **Send to:** **School Nurse-NFDL School District: B.Amadon, RN, J. Shafer LPN, E. Voss, LPN**
Name of Health Care Provider / Plan / Other

305 McKinley Street, North Fond du Lac, WI 54937 Or _____
Address Health Care Provider FAX #

Recipient (Contact) Phone Number: (**920**) **929-3754**

4) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From _____ (month/year) to _____ (month/year) **If left blank, only information from the past two (2) years will be disclosed.**

5) **INFORMATION TO BE DISCLOSED:** ☒ Verbal ☐ Written

☐ Billing Records related to (specify): _____
☐ Emergency Department Reports
☐ Hospital Summary – *a general abstract will be sent which includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports & ER.*
☐ Imaging Films (X-ray)
☐ Imaging Results
☐ Immunizations
☐ Lab Reports
☒ Procedure Op Reports
☒ Progress Notes/Updates
☒ Other: **Verbal communication**

I understand that the information to be disclosed may include information regarding genetic testing, and mental illness, alcohol/drug abuse, HIV Test results, AIDS/AIDS related illness, and developmental disabilities. We will disclose such information, unless you indicate below that you do not want such information disclosed:

☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities ☐ Genetic Testing

6) **EXPIRATION:** This Authorization is good until the following date / event: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) **PURPOSE** (Check all that apply - **copy fees may apply**)

☐ Further Medical Care – **no fee** ☐ Insurance Eligibility/Benefits – **fee $** ☐ Legal Investigation /Action – **fee $**
☐ Personal (at my request) - **possible fee $** ☐ Forms Completion - **possible fee $** ☒ Other: **School Nurse / School Health** (specify)

8) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize 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.

9) **SIGNATURE OF PATIENT / LEGAL REP:** _____ **DATE:** _____

If signed by a person other than the patient, complete the following:

1. Individual is: ☒ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin / executor of deceased ☐ activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only: **Signature/ID verified** ☐ Yes ☐ No Completed by: _____ (Name / Date) # of pages released _____

* 5 2 3 6 2 3 *

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
(HIM/ROI Authorization)

White – Medical Record
Yellow - Patient
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