AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

MAIL, FAX OR DROP OFF:

Turville Bay MRI & Radiation Oncology Center
Health Information Management (HIM)
1104 John Nolen Drive
Madison, Wisconsin 53713

Medical Records Phone # 608-259-4426
Imaging Fileroom Phone # 608-259-4393

HIM FAX #: 608-258-7832

PATIENT INFORMATION (please print legibly):

Name of Patient / Previous Names ______ Birth Date (mo/day/yr) ______ *MRN # (HIM office use only)* ______

Street Address ______ City, State, Zip ______ (Area Code) Phone Number ______

AUTHORIZES DISCLOSURE BY: *(where is info coming from)*

☐ ***Turville Bay MRI/RO Center*** **OR**

Other *(Specify facility/individual & address below, including phone/fax if known.)*

Name of Health Care Provider/Plan/Other ______

Clinic / Facility Name ______

Street Address ______

City, State, Zip Code ______

Phone Number ______ Fax Number ______

AUTHORIZES DISCLOSURE TO: *(where is info going to)*

☐ ***Patient*** **OR** ☐ ***Turville Bay MRI/RO Center*** **OR**

Other *(Specify facility/individual & address below, including phone/fax if known.)*

Name of Health Care Provider/Plan/Other ______

Clinic / Facility Name ______

Street Address ______

City, State, Zip Code ______

Phone Number ______ Fax Number ______

- **MRI Patients**: *Please check appropriate box(s):*
  - ☐ MRI ***Report***(s) **ONLY** from date(s) & condition(s): ______
  - ☐ MRI ***Images*** from date(s) & condition(s): ______
- **Radiation Oncology Patients**:
  - ☐ Radiation Oncology Note(s) from date(s) and/or condition(s): ______

The information to be released may include records related to psychiatric, developmental disability, alcohol or drug abuse, HIV test results/AIDS unless specified: ______

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

☐ Continuing Care
☐ Disability Determination
☐ Transfer to New Provider
☐ Patient Request (Personal) (There is a charge for CD)
☐ Insurance/Claim Purposes
☐ Workers Compensation
☐ Legal Purposes
☐ Other: ______

EXPIRATION DATE: This authorization is good for 2 (two) years from the date signed ***or*** until (date) ______

PLEASE REFER TO REVERSE PAGE FOR PATIENT RIGHTS INFORMATION

PATIENT SIGNATURE / LEGAL REP: ______ **DATE:** ______

If signed by other than patient, state relationship and authority to do so. *Please check appropriate box:*

☐ Parent of Minor
☐ Next of Kin of deceased
☐ Legal Guardian-attach court document
☐ Other ______
☐ POA for Healthcare-attach legal document

NOTE: I need the above records for an upcoming medical appointment on ______ (date).

DELIVERY: Unless noted otherwise, records will be sent directly to recipient. ☐ *Check here if patient wishes to pickup at the **HIM office on John Nolen Drive, Madison** on ______ (date).* [Please allow **minimum** of two (2) business days for processing your request.]

<u>YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION</u>

Right to Inspect or Receive a Copy the Health Information to Be Used or Disclosed
I understand that I have the right to inspect or receive a copy (which may be provided at a reasonable fee) 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 I have a right to receive a copy of this authorization.

Right to Refuse to Sign This Authorization
I understand that I am under no obligation to sign this form and that Turville Bay 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 that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Turville Bay. I am aware that my withdrawal 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.

Redisclosure
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards.

Copy Charges
Turville Bay does not charge patients for paper copies of their medical record nor is there a change for images and reports sent directly to another medical facility. There is a nominal charge for a personal copy of MRI images on a CD. Turville Bay may also charge a fee when releasing medial records to a third party, such as an attorney.

Copy or Facsimile (FAX) Valid as an Original.
I understand that a copy or fax of this authorization with my signature is valid as an original.