



Aurora Health Care

Aurora Two Rivers Clinic
Medical Records
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Date: Y9

To: Attention: Tammy

Company: Exam Management

Fax Number: 888-870-1729

From: Nancy Aurora Two Rivers Clinic

C: _____

Number of pages (including cover): 2

Subject: Aurora Release Form

CONFIDENTIALITY NOTICE: This facsimile may contain confidential and privileged information. Patient health information is confidential and released according to Wisconsin Statutes and Federal Regulations. Patient health information may not be redisclosed without further written authorization by the patient.

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Aurora Health Care® Milwaukee, Wisconsin

MRN / Chart #: _____

1) _____
Name Address City State Zip

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

2) **AUTHORIZES:**

Name of Health Care Provider / Plan / Other

Address

3) **TO DISCLOSE TO:**

Self [I hereby authorize _____ to pick up my records.] (Photo ID required.)

Name of Health Care Provider / Plan / Other

Address

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

5) **INFORMATION TO BE DISCLOSED:**

- All medical records related to (specify condition, treatment, etc.): _____
- All billing records related to (specify condition, treatment, etc.): _____
- Radiology films/images (specify test): _____
- Specific records/information as follows: _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):

- Alcohol/Drug Abuse
- HIV Test Results
- Mental Health / Developmental Disabilities

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): Further Medical Care Legal Investigation / Action
 Insurance Eligibility / Benefits Personal (at my request) Other: _____

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:



**AUTHORIZATION FOR DISCLOSURE
OF HEALTH INFORMATION**
(Pre Tab / Corres)

White - Medical Record / Yellow - Patient
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