Children's Hospital of Wisconsin

Kids deserve the best.

HOW TO REQUEST MEDICAL RECORDS FROM PSYCHIATRY HOSPITALS IN OUR COMMUNITY:

- **Aurora Psychiatric Hospital**
- **Milwaukee County Behavioral Health Division**
- **Rogers Behavioral Health**

Each of the above 3 facilities will require their own medical records release forms to be filled out and signed by all parties. These forms are included in this document. Fax numbers are also listed below to send the forms once completed and signed.

Aurora Psychiatric Hospital – Release of Information Department
1220 Dewey Avenue, Wauwatosa, WI 53213
P: 414-454-6497 ***F: 414-649-1329***

Milwaukee County Behavioral Health Division – Medical Records
9455 W. Watertown Plank Road, Milwaukee, WI 53226
P: 414-257-6984 ***F: 414-257-8167***

Rogers Behavioral Health – Medical Records/Health Information
P: 1-800-767-4411; Option 3 ***F: 262-646-5745***

Aurora Health Care® Milwaukee, Wisconsin

MRN / Chart #: _____

1) **PATIENT INFORMATION:**

_____
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, 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:** _____
Name of Health Care Provider / Plan / Other

_____ Or _____
Address Health Care Provider FAX #

Recipient (Contact) Phone Number: (_____) _____

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: _____

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: _____ *(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
© AHC 523623 (Rev. 10/15)

FAX TO: AURORA ROI DEPARTMENT – 414-649-1329

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION (BHD)
AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

1. _____ _____ _____
   Client/Patient Name Date of Birth Phone Number

2. Name of Agency/Organization Authorized to Release Information to BHD:
   _____

3. Mailing Address _____

4. Two-Way Exchange of Information: I authorize this information to be released between the designated organizations. Yes ☐ No ☐

5. Type of Information and Records Authorized for Release: All medical records related to (specify condition, treatment, etc.): _____ for date period of _____ to _____ for the following records:

- ☐ HIV Test Results/AIDs-related Diagnosis
- ☐ History & Physical
- ☐ Social History
- ☐ Psychiatric/Psychological Evaluations
- ☐ Mental Status Examinations
- ☐ Psychometric Assessments
- ☐ Substance Use Assessments
- ☐ Rehabilitative Assessments
- ☐ Medical Orders
- ☐ Medication Administration Records
- ☐ Treatment Plans
- ☐ Individual Education Plans
- ☐ Progress and Therapy Notes
- ☐ Progress Notes Related to AODA
- ☐ Lab and Diagnostic Test Results
- ☐ Court Orders
- ☐ Reports from Other Agencies
- ☐ Discharge Summary
- ☐ Other: _____

6. Effective Dates of Authorization. This authorization will expire 12 months from the date of signature.

7. Revocation. Authorization may be revoked by submitting a written notice of revocation effective the date of the written notice. Revocation does not apply to information released before the revocation notice.

8. Purpose and Use of Information Disclosed: I authorize the above named agency/organization to disclose the above indicated information for the purposes of coordinating services for me. I understand that my information may be re-disclosed pursuant to this release to establish my eligibility for programs or benefits or to coordinate my services.

9. Prohibition on Disclosure for Alcohol and Drug Abuse Records: Alcohol and drug abuse records are protected by Federal confidentiality rules, 42 CFR, Part 2, the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164, Wis. Adm. Code §§ HFS 92.05 and 92.06, and Wis. Stat. § 51.30. The Federal rules prohibit making any further disclosure of drug and alcohol abuse records unless expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. The Federal rules restrict any use of such information to criminally investigate or prosecute an alcohol or drug abuse patient.

10. Signature. I authorize the use and/or disclosure of my confidential information. I may receive a copy of this consent form. I may also inspect, and upon payment of the usual fee, receive a copy of the released information.

_____ _____
Signature Date

FAX TO: MILWAUKEE COUNTY MEDICAL RECORDS - 414-257-8167

Authorization for Disclosure of Protected Health Information

Rogers Behavioral Health
1-800-767-4411 select option "3"
Fax 1-262-646-5745

PLEASE COMPLETE ALL ITEMS ON THE FORM OR WE CANNOT RELEASE *If you have questions contact the above number.*

I authorize Rogers Behavioral Health to: ☐ Disclose to: ☐Obtain from:

1. PATIENT INFORMATION:

PATIENT NAME _____ PREVIOUS NAME _____ DATE OF BIRTH _____

PATIENT STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME TELEPHONE _____ WORK TELEPHONE _____

2. FACILITY NAME RELEASE TO / OBTAINED FROM:

AGENCY/FACILITY/PERSON _____ RELATIONSHIP TO PATIENT _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER _____ FAX NUMBER _____

3. SPECIFY THE INFORMATION TO BE DISCLOSED EITHER VERBALLY OR IN WRITING:

☐ **THE FOLLOWING INFORMATION CONTAINED IN MY HEALTH RECORD:**

☐ Psychiatric Evaluation/Findings ☐ Psychological Findings ☐ Legal Status/Court Records
☐ Medications ☐ Psychosocial Assessment (PSA) ☐ Treatment Plans
☐ History & Physical/Medical Evaluation ☐ Educational Planning Information ☐ Laboratory/Radiology/EKG reports
☐ Personal Recovery Plan / Discharge Instructions ☐ Discharge Summary ☐ Other: _____

☐ **ENTIRE MEDICAL RECORD FOR THE FOLLOWING DATE(S) OF SERVICE FROM _____ TO _____**

For continuing care purposes, an Abstract will be sent including Discharge Summary, Psychiatric Findings, History &Physical, Consultations, Medications, Personal Recovery Plan (Discharge Instructions) and Diagnostic tests (Lab, X-ray, EKG) if performed.

4. THE FOLLOWING INFORMATION WILL NOT BE RELEASED UNLESS SPECIFICALLY CHECKED BELOW:

☐ **HIV test results and related treatment** ☐ **Sexually transmitted diseases** ☐ **Genetic Testing**
☐ **Substance Use Disorder (SUD) treatment and/or referral ***

*** If authorizing the release of *SUD treatment and/or referral information*, please specify the information to be released (*Check all that apply*):**

☐ SUD assessments ☐ Aftercare plans ☐ Discharge summary including **SUD** information
☐ Treatment progress ☐ Treatment outcome ☐ SUD screen results
☐ SUD Medications ☐ Lab results related to SUD ☐ Other_____
☐ Compliance/non-compliance with recommended treatment plans, SUD screen results

5. RELEASE VIA: ☐ US MAIL ☐ FAX ☐ SECURE E-MAIL_____ ☐ PICK UP

6. EXPIRATION: This authorization expires on _____ *(insert date, time period or event).* Unless otherwise designated, this authorization will expire at midnight one year from the date of my signature below.

7. PURPOSE OF DISCLOSURE: *(Check all that apply.)* ☐ Continuing care ☐ Insurance eligibility/payment of claims

☐ Obtain collateral information ☐ Personal reasons ☐ Verify compliance with treatment ☐ Other: _____
(Specify purpose)

8.. YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I authorize the release of copies of the health information described above. I understand that I may revoke this authorization; I must do so in writing and present my written revocation **(HIM-056 Cancellation of Authorization)** to the Health Information Department. 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 understand that I have the right to inspect and/or receive a copy of certain health records as provided under Wisconsin Administrative Code §§ DHS 92.05 and 92.06. **I understand that I may be charged a fee for copying, postage and preparation of records associated with fulfilling this request.** I understand that Rogers may not condition treatment, payment, enrollment or eligibility for benefits upon execution of this authorization unless the services are being provided solely for the purpose of disclosing the information to a third party. **Redisclosure notice:** I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by the HIPAA Privacy Regulations, but that all recipients of information related to alcohol and drug abuse patient records are informed of the prohibition against disclosure as required by the Confidentiality Regulations found at 42 C.F.R. Part 2. This authorization will be effective for health records generated during the time frame specified above, up to and including the date of expiration of the authorization. By signing this Authorization for Disclosure of Protected Health Information, I am authorizing the release of all records applicable to this request that are maintained as part of Rogers' health record regarding me.
Photocopy/facsimile copy is as valid as the original document.

9. SIGNATURE OF PATIENT: _____ **DATE/TIME:** _____

SIGNATURE OF LEGAL REPRESENTATIVE: _____ **DATE/TIME:** _____

If signed by a Legal Representative, 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

TO BE COMPLETED BY ROGERS

The requested information was: ☐ US MAIL ☐ FAX ☐ SECURE E-MAIL ☐ PICK UP _____ *(Insert date)* by _____
(Name of Rogers's staff processing request)