emplify HEALTH by Gundersen

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. Patient Information

Name – Last, First, MI	Former Name(s)/Alias		
Street Address	City	State	Zip
Medical Record Number (if known)	Date of Birth	Phone	

I hereby Authorize: Written Communication Between 2 & 3. Check "Yes" to also authorize Verbal Communication Between 2 & 3 ☐Yes

2. Disclosed From ☐ Emplify Health (or):

Name (i.e., Health Care Facility, Provider)

Street Address

City State Zip

Phone Number Fax Number

3. Disclosed To: (Need FULL mailing address)

Name (i.e., Insurance Company, Lawyer, Provider)

Street Address

City State Zip

Phone Number Fax Number

4. **Please CHECK ONLY ONE BOX:**
☐ Paper ☐ Fax (provide fax number above) ☐ CD/DVD (requires PDF viewer) ☐ MyChart Patient Portal
☐ Email:_____ ☐ No records needed at this time.

5. **Date(s) of Information to be Disclosed:** _____ to _____. If left blank, only information from the past two (2) years will be disclosed.

6. **Type of Information to Be Disclosed:** ☐ Summary (last 2 years) ☐ Records pertaining to condition(s):_____
☐ AODA Assessment ☐ EEG ☐ Laboratory/Pathology Reports ☐ Psychiatric Evaluation
☐ Cardiac Procedures ☐ Facesheet ☐ Medication List ☐ Psychological Testing
☐ Clinic Notes ☐ Hospital Notes ☐ Problem List ☐ X-ray/Imaging Reports
☐ Consultation Reports ☐ Immunizations ☐ Other (specify):_____

7. **State and Federal Laws require specific authorization prior to disclosing certain information. Please check if you would like any or all the following information disclosed:**
☐ Behavioral Health ☐ Substance Use Disorder ☐ Developmental Disability ☐ HIV Test Results

8. **Purpose or need for disclosure:** ☐ Future Medical Care ☐ Insurance Eligibility/Benefits ☐ Personal
☐ Legal Investigation/Law Enforcement ☐ Other:_____

9. **Expiration Date:** This authorization will expire on _____/_____/_____, or ☐ after the above information has been released. If I do not indicate a date, this will expire one (1) year from the date of my signature below. This authorization covers records that were created or existing, on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed, up until expiration date. ☐ Other specific expiration date:_____

10. If custodial parent, have you ever been denied physical placement of the above minor? ☐ Yes ☐ No ☐ N/A
Do you have legal custody of the minor listed above? ☐ Yes ☐ No ☐ N/A

Your Rights with Respect to This Authorization

Right to Receive a Copy of this Authorization: I have a right to receive a copy of this authorization after I sign it. **Right to Refuse to Sign This Authorization:** I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment. **Right to Revoke This Authorization:** I have the right to revoke this authorization at any time by providing a written statement of revocation to the Privacy Office. My revocation will not be effective until the Privacy Office receives it and will not be effective regarding the uses and/or disclosures of my health information made prior to receipt of my revocation statement. **Re-disclosure:** If I authorize release of my health information to an individual or agency not covered by federal or state laws that prohibit re-disclosure, my health information may not remain confidential. **Right to Inspect and/or Copy of My Health Information:** I have the right to inspect and receive copies of my health information as permitted by law.

In accordance with the conditions listed above, I authorize the use and/or disclosure of my protected health information.

Signature of Patient/Representative:_____ **Date:**_____

Printed Name of Person Signing:_____

Signature of Minor (Age 14-17) Behavioral Health ONLY:_____

Indicate Relationship (if signing on behalf of the patient):
☐ Custodial Parent ☐ Court Appointed Guardian ☐ Next of Kin ☐ Personal Representative ☐ Health Care Agent
☐ Other: _____

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