



To Whom It May Concern:

To ensure the protection of your health information that is held at the Lakeshore Medical Clinics Billing Office, please complete the Authorization of Health Information Disclosure Form that is enclosed.

As of July 21, 2011, you and any authorized persons listed on your account will be required to provide a four digit pass code to obtain any abstract of your health information. Please select your pass code and write it in section 8 in addition to completing all other elements of this form.

If you have any questions or concerns regarding this matter, please feel free to contact Lakeshore Medical Clinic Patient Account Solutions Department at phone number and times specified below.

Thank you,

Lakeshore Medical Clinics Patient Account Solutions
Phone: 414-768-1845
Monday- Thursday 8am-6pm
Friday 8am-4pm



Authorization for Disclosure of Health Information Instruction Sheet

This authorization is not valid if one or more required elements are omitted. Failure to complete this authorization in its entirety will result in the denial of your request for us to disclose your/the patient's health information.

1. **Patient Information:** Fill in the complete name, address, date of birth and telephone number of the individual whose health information you are requesting be disclosed.
2. **Persons/organizations authorized to disclose patient's health information:** Fill in the name of the person or organization and their address.
3. **Persons/organizations authorized to receive patient's health information:** Fill in the name of the person or organization and their address.
4. **Delivery options:**
 - a. Mail: copies of your/the patient's health information will be mailed to the person or organization listed on this authorization.
 - b. View on-site: The information will be viewed or inspected on-site, and copies are not required.
 - c. Hand Carry/Pick up. You may authorize in writing for another individual to pick up copies of your/the patient's health information by indicating that person's name of this authorization.
 - d. Telephone (with security pass code). You may authorize another person to call and discuss your billing records and related health service payment information. A specific security pass code must be established and verified before any information will be released orally.
5. ***Health information to be disclosed:** You are not obligated to authorize a disclosure of your/the patient's health information. You may authorize disclosure of as much or as little of your/the patient's health information as you wish.

An abstract of health information MAY include:

Billing Record: Itemized bills, billing information forms, statements, invoice details, invoices pending review of the Central Billing Office or Insurance Carrier and findings after a review has been completed.

Payment Information: Any payments made on the account (i.e. patient or insurance payments), outstanding self-pay balances, outstanding insurance balances, details regarding any payment arrangements made on the account, and the ability to make payment arrangements towards the self-pay balance.

Note: Disclosure will not include specific diagnosis information.

Specify the dates for which you are requesting health information to be released.

If exact dates are not known, provide approximate dates and the related condition or procedure (for example, gallbladder surgery in March, 2001). We will not release any health information for dates not specifically identified.

6. **Purpose for need of disclosure:** Check applicable category or provide other reason if not listed.

Note: There may be a fee for requests from insurance companies, attorneys, and for health information requested for your own personal use.

7. ***Your rights with respect to this authorization:** Contact the Patient Account Solution Services Department to schedule an appointment to inspect your/the patient's billing and payment information.
8. **Pass code.** Select a 4 digit pass code that is easy to remember. This pass code must be provided by the third party and/or patient in order to obtain any abstract of your health record that is stored at the billing office. If the pass code is unknown by the third party or patient, LMC will be unable to access any abstract of the

patient's health record. Do not share the pass code with anyone other than third parties that are authorized to access your health record.

9. **Expiration date:** This authorization will be good for one (1) year unless specified otherwise. A valid authorization must be signed and dated after the date of service or event has taken place.
10. **Signature and Date:** It is your responsibility to review and understand this authorization. If you have any further questions about this authorization, please contact the Patient Account Solutions Services Department.
 - a. You are required to sign and date this authorization.
 - i. If you request health information that has been created after the date of this authorization, you will be required to complete another authorization.
 - ii. If you are a parent and have been denied physical placement of your child because it would endanger the child's physical, mental, or emotional health, the law denies you access to obtain the child's health information.
 - iii. A legal representative is a person authorized to obtain the patient's health information. This may include the parent, guardian, or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person who would be authorized in writing by the patient. Proof of such authority is required.
 - b. If no spouse survives a deceased patient: an adult member of the deceased patient's immediate family may qualify.
 - c. A court appointed temporary guardian to consent to the release of health information may also qualify. Proof of such guardianship is required.
 - d. Power of Attorney for Health Care takes effect upon finding that the patient is incapacitated. Two (2) physicians or one (1) physician and (1) psychologist, who personally examined that patient and sign a statement that the patient is incapacitated, makes this determination. Proof of such Power of Attorney for Health Care is required.
11. **Witness (when applicable):** A witness is required, when a patient is not physically able to sign his or her entire signature.



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) **Patient Information:** _____ (____) _____
Name of Patient/Previous Name Date of Birth Telephone Number

Address City/State/Zip

2) **Persons/Organizations Authorized to Disclose Patient's Health Information:**

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip

3) **Persons/Organizations Authorized to Receive Patient's Health Information:** Self; or

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip

I understand that if the person(s) and/or organization(s) listed above are not governed by Federal and Wisconsin confidentiality laws, my health information disclosed as a result of this Authorization may no longer be protected by such laws and that my health information may be re-disclosed without obtaining my authorization.

4) **Delivery Options:** Mail View On-Site Other _____
 Hand Carry/Pick-Up (Date & Time) _____
Authorized Person to Pick-Up Health Information _____

5) **Health Information to be Disclosed:** (Check applicable information)

Billing Records _____
 Other _____
For the following date(s) or service type(s) _____

I DO NOT WANT THE FOLLOWING BILLING INFORMATION DISCLOSED: (Check applicable information)

Human Immunodeficiency Virus (HIV) Testing Developmental Disability Records Mental Health Records
 Alcohol and Drug Abuse Records

6) **Purpose for Need of Disclosure:** (Check applicable categories)

Guardianship/P.O.A. Legal Investigations At the Request of the Individual Insurance Eligibility/Benefits
 Other (specify): _____

7) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION ARE SET FORTH ON THE BACK OF THIS AUTHORIZATION.**

8) **Select a four digit pass code.** _____

9) **Expiration Date:** This Authorization is good until the following date(s)/event _____.
If no date or event is specified, this Authorization will expire one (1) year from the date signed.

PROHIBITION ON RE-DISCLOSURE OF ALCOHOL AND DRUG, DEVELOPMENTAL DISABILITY AND MENTAL HEALTH RECORDS:

This information is protected by Federal and Wisconsin confidentiality laws. Such laws prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by such laws. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules (42 C.F.R. Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

10) **Signature of Patient/Legal Rep:** _____ **Date:** _____
Relationship or Authority to Act for the Patient _____

(If you are signing as a parent of the minor patient listed above, you are declaring that you have not been denied physical placement of the child because such placement would endanger the child's physical, mental, or emotional health.)

11) **Witness (when applicable):** _____ **Relationship** _____ **Date** _____

5) **HEALTH INFORMATION TO BE RELEASED:** You are not obligated to authorize a disclosure of your/the patient’s health information. You may authorize disclosure of as much or as little of your/the patient’s health information as you wish.

Billing and payment records regarding health information MAY include:

Billing Record: Itemized bills, billing information forms, statements, invoice details, invoices pending review of the Central Billing Office or Insurance Carrier and findings after a review has been completed.

Payment Information: Any payments made on the account (i.e. patient or insurance payments), outstanding self-pay balances, outstanding insurance balances, details regarding any payment arrangements made on the account, and the ability to make payment arrangements towards the self-pay balance.

7) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

Right to Inspect or Copy the Health Information to be Used or Disclosed for this Authorization: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this Authorization.

Right to Receive Copy of this Authorization: I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of this Authorization.

Right to Refuse to Sign this Authorization: I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. Unless allowed by law, my refusal to sign this Authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits.

Right to Revoke this Authorization: I understand that written notification must be presented to the Medical Records Department to cancel this Authorization. I understand that my withdrawal will not be effective as to uses and/or disclosures of my/the patient’s health information (i) already made in reliance on this Authorization by the person(s) and or organization(s) listed in Section 2 and 3 of this Authorization or (ii) if this Authorization was obtained as a condition of obtaining insurance coverage, to the extent that such person(s) and/or organization(s) have the right to contest a claim under the policy pursuant to which such coverage is provided, or the policy itself.