HOW TO REQUEST MEDICAL RECORDS FROM MILWAUKEE-AREA PSYCHIATRIC HOSPITALS

Each of the three facilities listed below 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

Phone: 414-454-6497
Fax: 414-649-1329
Email: aurorareleaseofinfo@aurora.org

Milwaukee County Behavioral Health Division

Medical Records

9455 W. Watertown Plank Road, Milwaukee, WI 53226

Phone: 414-257-6984
Fax: 414-257-8167

Rogers Behavioral Health

Medical Records/Health Information

34700 Valley Road, Oconomowoc, WI 53066

Phone: 1-800-767-4411; Option 3
Fax: 262-646-5745
Email: releaseofinformation@rogersbh.org

Aurora Health Care® *Milwaukee, Wisconsin*

MRN: ____________

1) **Patient Name:** ____________ **Previous Name:** ____________

Address ____________ City ____________ State ______ Zip ______

2) **AUTHORIZES:** Daytime Phone: (_____) ____________ Date of Birth: ____________

- ☐ Aurora Psychiatric Hospital
- ☐ Aurora Behavioral Health Center *(site)*: ____________
- ☐ Aurora Sheboygan Memorial Medical Center
- ☐ Aurora Health Care Metro, Inc.
- ☐ Other: ____________

3) **TO DISCLOSE TO:** ☐ Self ***OR*** ☐ Recipient Name/Facility ____________

Relationship to Recipient (***specify*** insurance, therapist, school, family member, etc.): ____________

Address ____________ City ____________ State ______ Zip ______

☐ Will pick-up ☐ Fax to: ____________

Recipient (Contact) Phone Number: (_____) ____________

4) ☐ **CHECK HERE IF AUTHORIZATION IS RECIPROCAL (in other words, the disclosing party and the recipient(s) may mutually exchange the information noted below.)**

5) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From ____________ (month/year) to ____________ (month/year)

6) **INFORMATION TO BE DISCLOSED:** ☐ **Verbal** ☐ **Written**

- ☐ Alcohol & Other Drug Abuse (AODA) Assessment
- ☐ Discharge Instructions
- ☐ Discharge Summary
- ☐ Diagnostic Tests: ____________
- ☐ History & Physical
- ☐ HIV Test Results
- ☐ Identity and Presence in Treatment
- ☐ Lab Results
- ☐ Legal Status/Court Records
- ☐ Medications/Medication Profile
- ☐ Mental Health Assessment
- ☐ Progress Notes/Updates
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan
- ☐ Billing Records related to (specify): ____________
- ☐ Other (specify): ____________

____

7) **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.

8) **PURPOSE** (check all that apply): ☐ Care Coordination ☐ Further Follow-up Care ☐ Insurance Eligibility / Benefits ☐ Legal Investigation/Action ☐ Obtain Collateral Information ☐ Personal (at my request) ☐ Verify Compliance with Treatment ☐ Other: ____________

9) **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 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.

10) **SIGNATURE OF PATIENT:** ____________ **DATE:** ____________

SIGNATURE OF LEGAL REPRESENTATIVE: ____________ **DATE:** ____________

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

* By signing above, I hereby declare that I have not been denied physical placement of this child.

RELEASED BY: ____________ **DATE RELEASED:** ____________

AUTHORIZATION FOR DISCLOSURE INCLUDING BEHAVIORAL HEALTH INFORMATION AND/OR RECORDS
(HIM/ROI Auth-BH)

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Aurora Health Care® Milwaukee, Wisconsin

PATIENT HEALTH INFORMATION ACCESS REQUEST FORM

MRN: ______________________

Today's Date: __________________

Patient Information:

____

First Name MI Last Name

Address: __________________________________ City: ________________ State: _____ Zip: ___________

Date of Birth: _______________ Phone Number: ________________ Previous Name: ____________________

Request that Aurora Health Care disclose my health information to:

☐ Myself or ☐ ____

Name of Health Care Provider / Insurance / Attorney / Other

Delivery Method Requested:

☐ Mail To: ____

Address City State Zip

☐ Email address: ____

Format Requested (Fees may apply):

☐ Encrypted CD ☐ Paper ☐ Other ____

☐ Encrypted email ☐ Non-Encrypted email (Requestor was informed and understands the risks of receiving records via unsecured email and that personal health information could be accessed by a third party while in transit. Requestor still wants the records in this manner.)

Information to be Disclosed and Dates:

☐ 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: ______________________________

Patient/Personal Rep Signature: ____

Print Name and Signature

Aurora will accept any written request from a patient for access to or copies of their own medical record. This form is not required. However, it will provide Aurora with all needed information to assure an accurate response.

For Office Use Only:

Health Information Department Verification (Staff *initial* box when verification has been confirmed):

☐ Demographic information (Name, DOB, Address, Phone Number, email address, last 4 digits of SS#)

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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: ______________________________

   ☐ CARS ☐ Team Connect ☐ Care Coordination (Crisis Episode) ☐ Access Clinic **ROI Medical Record Fax 414-257-8167**

3. Phone number__________________ 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, Use of Information Disclosed, and Further Disclosure: 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 as necessary to carry out payment and/or healthcare operation activities (but not for treatment purposes) or for Medicare, Medicaid or CHIP audit or evaluation, including a civil investigation or administrative remedy, as permitted by 42 CFR Part 2, and as further controlled by applicable State of Wisconsin and Federal confidentiality rules, including, but not limited to: 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.

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. Further, I understand that in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data. I understand that I do not need to give any further permission for the information to be shared with the person(s) or organization(s). I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Witness Date

ROGERS Behavioral Health

34700 Valley Road, Oconomowoc, WI 53066
PHONE: 800-767-4411, option 3 FAX: 262-646-5745 WEBSITE: rogersbh.org

Authorization to Release Protected Health Information

1. Patient Information:

First Name | Middle Initial | Last Name | Former Name(s) | Date of Birth

Street Address | City | State | Zip | Phone Number

2. I authorize (check all that apply)**:**

□ Rogers Behavioral Health – California □ Rogers Behavioral Health – Florida □ Rogers Behavioral Health – Georgia
□ Rogers Behavioral Health – Illinois □ Rogers Behavioral Health – Minnesota □ Rogers Behavioral Health – Pennsylvania
□ Rogers Behavioral Health – Tennessee □ Rogers Behavioral Health – Washington □ Rogers Behavioral Health – Wisconsin

3. □ To Release To: □To Obtain From:

Agency/Facility/Person | Phone Number | Fax Number

Street Address | City | State | Zip

4. Information to be Released: Dates of Service: ______________________________ □ Entire Record

If no end date entered, will continue to apply through date of expiration of this authorization

□ Psychiatric Evaluation □ Discharge Summary □ Treatment Plans □ Clinical Summary
□ Medication List □ Education Planning □ Discharge Instructions □ History & Physical/Consult
□ Date of Service Letter □ Safety Plan □ Other: ______________________________

**For continuing care purposes, an abstract will be sent (Discharge Summary, Psychiatric Eval, History & Physical/Consults, Medications)*

5. Type of Information: I understand that the information to be released may include information regarding genetic testing, substance use disorder, HIV test results, and sexually transmitted infections. (*check below if you do **not** want this information released):*
□ Substance Use Disorder Treatment □ HIV test results and related treatment □ Sexually transmitted infections □ Genetic Testing

6. Method of Delivery: (check one)
□ US Mail □ Fax □ Digital Flash Drive □ Secure Email: ______________________________ □ Verbal

7. Purpose of Disclosure: (check all that apply)
□ Continuing Care □ Legal □ Education Planning □ Personal □ Insurance eligibility/payment □ Verify compliance with treatment
□ Other: ______________________________

8. Expiration: This authorization will expire at midnight one year from the date of my signature below unless otherwise designated. Other expiration date, time period, or event: ____________________ This authorization will apply to health records generated during the time frame specified above up to the date of expiration of the authorization and will include financial information related to this account until the close of the account.

9. Patient Rights Regarding This Authorization:
I authorize the release of the health information described above. By signing this form, I am authorizing the release of all records applicable to this request that are maintained as part of Rogers' health record regarding me. I understand that I may revoke this authorization; I must do so in writing and present the Cancellation of Authorization Form HIM-056) to the Health Information Department. 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 I may be charged a fee for preparing and delivering the records to fulfill 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 releasing the information to a third party. 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. I understand that I have a right to a copy of this authorization and that I have the right to a inspect or receive a copy of the material to be disclosed as required under Wisconsin §§ DHS 92.05 and 92.06. I understand that a photocopy/facsimile copy of this document is as valid as the original form.

10. Authorization:

If patient is unable to sign, give reason: ____________________

Signature of Patient **Date/Time**

Witness Print Name & Date: ____________________

Signature of Legal Representative **Date/Time**

If signed by a person other than the patient, patient is:
□ a minor □ legally incompetent or incapacitated □ deceased

Legal Authority: □ parent □ legal guardian □ activated power of attorney for healthcare (If you are signing as a parent of a minor patient, you are declaring that you have not been denied physical placement or parental rights of the child because such placement would endanger the child's physical, mental, or emotional health)

Comments (optional)**:** ______________________________

Redisclosure Notice for Recipient of Information: If this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2), 42 CFR part 2 prohibits unauthorized disclosure of these records.

For office use: Signature verified: _________ (initials)