wisconsin fertility INSTITUTE

Medical Records Release Policy and Procedure

In response to the Health Insurance Portability and Accountability Act (HIPPA) of 1996, physicians have been faced with greater complexities when releasing medical records. In an effort to protect patient confidentiality, as well as comply with government regulations, Wisconsin Fertility Institute has developed policies and procedures to insure that your confidential medical records are handled in a manner meeting all necessary guidelines.

Medical Records will be released only upon written request from the patient. Written requests must be in accordance with the Uniform Health Care Information Act.

Wisconsin Fertility Institute will only release records that were created and maintained by our doctors and clinic. We will not release records received from other clinics or providers.

The requirements for a valid authorization to release medical records are:

- In writing, dated and signed by patient
- Specifically identifies patient
- Specifically identifies the healthcare provider who is to make the disclosure
- Specifically identifies the information to be disclosed

Note: *an authorization which affects a medical record in which information concerning the performance or results of HIV (AIDS virus), STD testing, substance abuse, and mental or psychiatric treatment must specifically authorize the release of such test and/or treatment information or it will be excluded from the records release.*

- Specifies the name, address and institutional affiliation of the person or entity to whom the information is to be disclosed

Except for authorizations to provide information to third-party payers, authorizations are valid for 2 years. Patients can specify a shorter period of time if desired.

Revocation must be in writing; an authorization can be revoked at any time unless:

- Needed to secure payment for services rendered; or
- Other substantial actions have been taken in reliance on the authorization (e.g. a claim has been made under a life insurance or disability policy)

GUIDELINES FOR COMPLETION OF AUTHORIZATION TO RELEASE MEDICAL INFORMATION FROM WISCONSIN FERTILITY INSTITUTE

1. This form can be used to release medical records from WFI.

2. Complete the patient's name, daytime phone #, and date of birth.

3. Complete the name and address of the person/facility that the records are to be released to.

4. Check the reason for releasing this information (Purpose of this Disclosure).

5. Identify the appropriate dates of service for the records that are to be released.

Please initial if you would like your future records to be released as part of this completed authorization.

6. Check the appropriate information that is to be released (copied and/or faxed).

7. Review your rights for this authorization.

8. Review the expiration date of the authorization. If you would like a different expiration date, please indicate.

9. Obtain the patient or legal representative's signature (relationship) and date.

10. If this request relates to AIDS/HIV, Mental Health Care, Alcohol/Drug Use, or Development Disabilities, please sign and date under the specified section.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ Daytime Phone #_____ Date of Birth _____

AUTHORIZES DISCLOSURE FROM:
Wisconsin Fertility Institute (WFI)
ATTN: Release of Information
3146 Deming Way
Middleton, WI 53562

TO RELEASE MEDICAL INFORMATION TO:
_____
Name of Health Provider/Organization/Individual
_____
Street Address
_____
City State Zip

PURPOSE OF THIS DISCLOSURE:
❒ Transferring to New Physician/Continued Medical Care (Customary to release up to 2 years of most recent information)
❒ Disability Determination ❒ Legal Investigation ❒ Payment of a Claim/Benefits
❒ Personal Use ❒ Other, please specify _____

INFORMATION TO BE DISCLOSED:
(Note: Please see Disclosures Requiring Special Consent for AIDS/HIV, Mental Health, Alcohol/Drug Use, and Developmental Disabilities.)

Date Range: _____ to _____

_____ *Initials* This authorization shall also extend to records of future treatment, after the date of signature as long as such treatment occurs while this authorization is still in effect.
(Please initial if you also wish to have future records not yet created to be included with this release)

❒ Office Visit Notes ❒ Ultrasound Reports ❒ Ultrasound Pictures
❒ Laboratory Reports:_____
❒ Specific information related to:_____
❒ I authorize verbal communication between _____ & _____
regarding my care and treatment at Wisconsin Fertility Institute.

YOUR RIGHTS REGARDING THIS AUTHORIZATION
Right to inspect or receive a copy of the health information to be used or disclosed: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.
Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.
Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Wisconsin Fertility Institute. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. Wisconsin Fertility Institute will not condition treatment on the completion of this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.
Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.
EXPIRATION DATE: This authorization is effective for one (1) year from the date signed unless otherwise indicated.

_____
Date (Optional)

_____ _____
Patient or Legal Representative Signature/Relationship Date of Signature

DISCLOSURES REQUIRING SPECIAL CONSENT:
My signature below specifically authorizes the release of health information relating to testing, diagnosis and treatment for:
❒ AIDS/HIV/STDs ❒ Mental Health Care ❒ Alcohol/Drug Use ❒ Developmental Disabilities

_____ _____
Patient or Legal Representative Signature/Relationship Date of Signature
(Photostatic copy shall be valid as original.) Revised 06/01/2007