PRINT RESET

Children's Wisconsin

Skywalk Pharmacy

Authorization for the Use or Disclosure of Protected Health Information

1. PATIENT INFORMATION:

Last Name | MI | First | Date of Birth (__/__/__)

Address | City | State | Zip

(_____)_____ Cell Phone

(_____)_____ Home Phone

2. I AUTHORIZE INFORMATION TO BE RELEASED FROM:

- ☐ Children's Wisconsin Skywalk Pharmacy
- ☐ Other: _____

3. INFORMATION WILL BE RELEASED TO:

_____ Name / Facility

_____ Address

_____ City | State | Zip

(_____) _____ Phone | (_____) _____ Fax

4. REASON INFORMATION IS NEEDED: (Copy fees may apply)

☐ Personal Use ☐ Legal Use ☐ Insurance Use

☐ Other: _____

5. PHARMACY RECORD INFORMATION TO BE RELEASED: (See back for important tips):

☐ Prescription Fill History with Paid Amounts

* Requested Dates: From: _____ To: _____

☐ Other: _____

6. FORMAT OF RECORDS TO BE RELEASED:

Check One: ☐ Secure Email ☐ Mail (to information in #3 above) ☐ Fax (to information in #3 above)

7. EXPIRATION DATE:

This Authorization is valid until the following date/event: (not to exceed 1 year): _____

If no date is listed, this authorization is good for one (1) year from the date signed below. This includes records that are created after the date this authorization is signed, up until the expiration date.

8. PLEASE SEE BACK SIDE OF THIS FORM BEFORE SIGNING FOR MORE INFORMATION.

I have read, understand and agree to the information above and on the back of this form, I authorize the release of my/the child's Patient Health Information.

_____ Patient, Parent or Legal Guardian Name

_____ Signature

Date

☐ Parent - I declare that I am the above named minor child's guardian.

☐ Self ☐ Legal Guardian (must provide paperwork) ☐ Other (please list): _____

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ADDITIONAL INFORMATION REGARDING THE RELEASE OF MEDICAL RECORD INFORMATION FROM CHILDREN'S WISCONSIN

PLEASE READ THE FOLLOWING BEFORE VOLUNTARILY SIGNING THE FRONT OF THIS RELEASE FORM.

All of Children's Wisconsin entities respect the patient's right to privacy of confidential medical information. I have had an opportunity to review and understand the content of both sides of this form.

Disclosure (release) of information.

Federal and Wisconsin Confidentiality laws protect this information. The laws forbid this information to be re-released unless:

- The person whose information it is gives written consent, or
- Otherwise permitted by law

I understand that the person receiving this information (recipient might re-release this information. If this happens, the information may not be protected by the state and Federal laws anymore.

RIGHT TO REFUSE TO SIGN

I understand that this authorization is voluntary and that I can refuse to sign it. Treatment, payment or enrollment in a health care plan will not be affected if you refuse to sign.

REVOCATION

I understand that I have the right to revoke this authorization at anytime. I must do so by submitting my revocation in writing to the Medical Record Department. My revocation will not apply to confidential information that has already been released in response to this or another Disclosure form.

LIABILITY

All Children's Wisconsin entities, employees, officers and attending physicians are released from legal responsibility or liability for the release of information as indicated on this form.

VALIDITY OF FORMS

A photocopy or facsimile (fax) of this Disclosure Form is as valid as the original.

IMPORTANT TIPS: For each numbered area on the form:

#1- Print and be sure to include the date of birth of the patient.
#2- Be specific about where you want records to be released from.
#3- If releasing to a business, include the name and suite number.
#4- If military request, place the reason under Other.
#5- Be specific regarding the records to be released.
#6- Choose how the information is to be released.
#7- This authorization will be valid for one (1) year
#8- Be sure to sign and date the form.

* Be sure the form is filled out completely to ensure prompt processing.