NEUROLOGIC ASSOCIATES OF WAUKESHA
MEDICAL RECORDS RELEASE REQUESTS

Neurologic Associates wants to assist you in getting your medical records to other healthcare providers when you need them. Neurologic Associates of Waukesha Medical Records Department will process a release request from our office to another healthcare provider, free of any charge to you, with the attached signed authorization or a faxed request from your doctor's office requesting your medical records.

It is important to us that you understand the process for requesting your medical records and the requirements around releasing those records. We have attached our authorization form for requesting any release of your medical records. A fee schedule pertaining to the release of your records is included on the back side of this informational sheet. Please read the forms carefully.

All completed release forms should be submitted to the Neurologic Associates of Waukesha Medical Records department at 1111 Delafield Street, Suite 105, Attn: Medical Records, Waukesha, WI 53188 or Faxed to 262-522-7286.

FEES FOR RECORDS

Neurologic Associates of Waukesha uses HeatlhPort Technologies, LLC to process and fulfill all other requests for copy or release of your medical record. HealthPort Technologies charges a reasonable fee for, copying, postage and preparation of records to fulfill this request. All fees are based on the applicable laws governing release of Health information. HealthPort Technologies will process your records within 3 to 10 business day of receiving the completed release request form. Please see the HealthPort document on the back of this page. HealthPort Technologies may release up to 5 pages free of charge.
HealthPort Customer Service: 1-800-367-1500

You may call our Medical Records Department at 262-522-7840 with any questions regarding your request or these forms.

Thank you for allowing Neurologic Associates of Waukesha to be part of your healthcare team.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Name of Patient/Previous Names _____ Birth Date _____ Medical Record Number _____

Street Address _____ City, State, Zip _____ Phone Number _____

AUTHORIZES DISCLOSURE BY:

- ☐ PHC, Oconomowoc Memorial Hospital
- ☐ PHC, Waukesha Memorial Hospital
- ☐ PHC, Behavioral Medicine Center
- ☐ PHCMA – Clinic/Provider _____
- ☐ ProHealth Solutions Participant _____
- ☐ Other: _____

DISCLOSURE OF HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip Code _____

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed:*

☐ Billing Records ☐ Discharge Summary ☐ History & Physical ☐ Consultation ☐ Operative Report ☐ ED Report

☐ Pathology Report ☐ Radiology Report ☐ Radiology Films ☐ Laboratory Report ☐ Rehab Notes

☐ Progress Notes ☐ Other: _____

DISCLOSURES REQUIRING SPECIAL CONSENT: In compliance with Wisconsin Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply.

☐ HIV/AIDS* ☐ Mental/Behavioral Health Conditions ☐ Drug/Alcohol Abuse/Treatment ☐ SANE ☐ SANE Photos

FOR THE FOLLOWING DATES: From: _____ To _____

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

☐ Continuing Care ☐ Transfer to New Provider ☐ Insurance/Claim Purposes ☐ Legal ☐ Personal Use

☐ Disability Determination ☐ Workers Compensation ☐ Vocational Rehab Eval

Other: _____

Check One: ☐ Verbal Release ☐ Paper Release ☐ Electronic/Digital Release (specify) _____

Release by: ☐ US Mail ☐ Fax _____ ☐ Pick-Up: Location _____

YOUR RIGHTS WITH RESPECT TO 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 (may be provided at a reasonable fee) of the health information I have authorized to be used or disclosed by this authorization form. **Right to Receive Copy of This Authorization** -- I understand that if I agree to sign this authorization, I may receive a copy. **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form and that ProHealth Solutions Participant may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.** **Right to Withdraw This Authorization** – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to ProHealth Care's Release of Information Department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organizations(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. ***HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State laws and a list of those persons/organizations is available upon request. ****WI Statues 51.30 and 252.15** requires patient authorization to disclose health information for payment purposes. **Copy or Facsimile (FAX) Valid as an Original.**

This information has been disclosed to you from records protected by Federal (42 CFR Part 2) and Wisconsin (51.30) confidentiality rules. The Federal rules prohibit you from 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 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

EXPIRATION DATE: This authorization is good until the following dates(s) _____ or 6 months from the date signed.

SIGNATURE OF PATIENT/LEGAL REP: _____ DATE: _____ TIME: _____

RELATIONSHIP TO PATIENT: _____

Information Released By: _____ DATE: _____ TIME: _____

Acknowledgement of Medical Record Processing Fee

The Health Insurance Portability and Accountability Act (HIPAA), in addition to Wisconsin law, allow a fee to be assessed to patients for medical record request processing.

Neurologic Associates has partnered with HealthPort Technologies to process and fulfill your request for a copy of your medical record. The regulated fee for copies of records from Wisconsin providers is detailed below:

RATES (7/1/15 - 6/30/2016):

1-100pgs @ $0.39ppg

101+pgs @ $0.31ppg

Plus actual shipping and sales tax

By signing below, I acknowledge that a fee will be charged for a copy of my medical record. ***I agree to pay this fee upon receipt of HealthPort's invoice.***

Name (please print): _____ Phone: _____

Address:

_____

Street City State Zip

Patient Signature: _____ Date: _____

(or authorized representative; if you are an authorized representative and not the patient, please list your authority for obtaining the record)

Email address for electronic delivery request for medical record:

_____

Payment must be remitted directly to HealthPort Technologies as directed on the HealthPort invoice you receive.

HealthPort Technologies, LLC - Release of Information Processing Center
120 Bluegrass Valley Parkway, Alpharetta, GA 30005
Customer Service: 800-367-1500