OAKLEAF SURGICAL HOSPITAL

RIVER PRAIRIE Surgery Center

Phone: 715.831.8130 ROI Fax: 715.952.0972

ROI*
ROI

REQUEST/ AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name/Previous Name(s) | Date of Birth | Phone Number

Street Address, City, State, Zip Code

RELEASE INFORMATION FROM:

☐ **OakLeaf Surgical Hospital- 1000 OakLeaf Way, Altoona, WI 54720**

☐ **River Prairie Surgery Center- 3119 Woodman Drive Altoona, WI 54720**

☐ **Both Facilities**

RELEASE INFORMATION TO:

☐ Self: **Delivery Options**: ☐ Pick Up ☐ Mail to address above ☐ Fax _____ ☐ Email _____

Format: ☐ Paper ☐ Electronic Media

☐ Send to Individual/ Healthcare Facility/Other:

Name: _____

Street Address _____

City, State, Zip Code _____

Phone: _____ Fax: _____

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

Date(s) of Service: _____ **(If left blank only information from last 2 years will be disclosed)**

☐ Operative Reports ☐ Discharge Summary ☐ Pathology Reports ☐ Abstract (D/S Summary, H&P, Consult, Path, Operative Report, Lab, Radiology Implant)

☐ History & Physical ☐ Radiology Reports ☐ Progress Notes ☐ Other _____

☐ Consultations ☐ Radiology Images/CD ☐ Laboratory Reports

In compliance with Wisconsin Statutes, to release privileged information, please release records pertaining to:

☐ Mental Health ☐ Developmental Disabilities ☐ Alcoholism

☐ HIV (AIDS) ☐ Sexually Transmitted Disease ☐ Drug Abuse

PURPOSE OF DISCLOSURE:

☐ Continuation of Care ☐ Legal Investigation ☐ Insurance Benefits ☐ Personal

We may be prohibited from making certain information available to you or to your representative, including:
Psychotherapy, Information related to medical research in which you have agreed to participate, Information related to legal proceedings, Information obtained under a promise of confidentiality, Information that federal or state laws prevent us from disclosing, Information for which the disclosure may result in harm or injury to your or to another person, Information related to certain lab results subject to CLIA.

YOUR RIGHTS WITH RESPECT TO THIS REQUEST:
Within the limitations of law, we will make every effort to accommodate your request. We will complete our review of your request and as requested either provide a copy or arrange for you to inspect your records within 30 days of your request or provide you with a written explanation of any restriction on the information that we can provide you. The organization 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. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to OLSH/ RPSC. I understand 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.

EXPIRATION: This Authorization is good until the following date/event: _____
Or if this item is left blank, the authorization will expire in 1 year from the date signed.

_____ _____

Signature of Patient or Legal Representative/Relationship | Date

_____

Printed Name of Patient

01.09.2026

Staff Use: Staff Initials _____ ☐ ROI Send Records ☐ Scan to Chart