QuadMed

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. PATIENT INFORMATION

____ _____/____/_____

Last MI First Previous Name (if applicable) Date of Birth

Street Address City State Zip

Preferred Phone Number Preferred Email

2. PROVIDER/FACILITY/PERSON INFORMATION

Provider/Facility/Person

Street Address City State Zip

Phone Fax Email

I AUTHORIZE QUAD/MED, LLC AND ITS ASSOCIATED MEDICAL PRACTICES ("QUADMED") TO:

☐ ***Disclose to*** provider/facility/person: ☐ ***Obtain from*** provider/facility/person:

3. INFORMATION TO BE DISCLOSED

- ☐ Billing Records
- ☐ Consults
- ☐ Entire Medical Record
- ☐ History & Physical
- ☐ Immunizations
- ☐ Laboratory Report(s)
- ☐ Prescriptions
- ☐ Radiology Images
- ☐ Radiology Report(s)
- ☐ Other (please specify):____

The following information WILL NOT be released unless specifically checked below (as defined by applicable federal and state laws):

- ☐ Alcohol/Substance Use
- ☐ Behavioral/Mental Health
- ☐ Genetics Testing
- ☐ HIV Test Results/Treatment
- ☐ Sexually Transmitted/Other Communicable Disease(s)

In select states, patient care is provided by a physician-owned medical practice contracted with QuadMed.

4. DATES OF SERVICE TO BE DISCLOSED

From: _____/_____/_____ To: _____/_____/_____. If left blank, only information from the past two (2) years will be disclosed or obtained.

5. PURPOSE OF DISCLOSURE *(CHECK ALL THAT APPLY)(COPY FEES MAY APPLY)*

- ☐ Continuing Care
- ☐ Disability Determination
- ☐ Insurance/Payment of Claims
- ☐ Litigation/Legal
- ☐ Personal Use
- ☐ Transfer of Care
- ☐ School Use
- ☐ Workers' Compensation
- ☐ Form Completion
- ☐ Other (please specify): ____

6. PREFERRED FORMAT/METHOD OF DELIVERY *(CHECK ONE)*

Release via (check one): ☐ Fax ☐ Secure Email ☐ US Mail ☐ Verbal ☐ View In-Person
Specify fax #, email/mailing address: ____

7. EXPIRATION

This authorization expires on ______________________________ *(insert date, time period or event)*. Unless otherwise designated, this authorization will expire one (1) year from the date of the requester's signature below.

8. YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

This Authorization is Voluntary. I understand this authorization is voluntary. Unless allowed by law, my refusal to sign this authorization will not affect my ability to receive treatment from QuadMed or associated health care providers. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy laws.

Right to Revoke this Authorization. I understand that I have the right to revoke this authorization at any time and I must do so in writing. My revocation will not apply to uses and/or disclosures that have already occurred under this authorization. To revoke my authorization, I must provide a written request for revocation to QuadMed, Attention: Privacy Officer, N64W23110 Main Street, Sussex, WI 53089.

Right to Inspect and Copy. I understand that I have the right to inspect and/or receive a copy of certain health records I have authorized to be used and/or disclosed under this authorization. I understand that I may be charged a fee for copying, postage and/or preparation of records associated with fulfilling this request. Photocopy/facsimile copy is as valid as the original document(s).

Right to Receive a Copy of this Authorization. If I agree to sign this authorization, which I am not required to do, I may be provided with a signed copy of this form.

NEW YORK RESIDENTS ONLY: If you are authorizing the release of HIV-related information, the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal and state law. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting your rights.

9. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

______________________________ ______________________________ _____/_____/_____

Signature Printed Name Date

If signed by a person other than the patient, you must complete the following:

1. Individual is: ☐ A Minor ☐ Legally Incompetent/Incapacitated ☐ Deceased
2. Legal authority: ☐ Parent* ☐ Legal Guardian (must provide paperwork)
   ☐ Other (please specify & provide paperwork): ________________________

**By signing above, you are declaring that you have not been denied physical placement of the minor child by a court of law or had your parental rights terminated by a court order.*

FOR INTERNAL USE ONLY:

☐ Request sent to medical records for processing

☐ Request processed by clinic*

**Information in Epic should be released via the Quick Disclosure activity.*

In select states, patient care is provided by a physician-owned medical practice contracted with QuadMed.

QuadMed Compliance

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION INSTRUCTIONS

QuadMed complies with applicable Federal civil rights laws. We do not exclude or treat people differently based on race, color, national origin, age, disability or sex.

The authorization form is not valid if one or more required elements are left blank. Failure to complete all required elements may result in a delay or denial in processing your request.

Completed forms may be submitted electronically or in person:

QuadMed
Attn: Medical Records Processing
W64W23110 Main Street, Sussex, WI 53089
Email: MedicalRecords@quadmedical.com
Fax: (414) 622-3809

SECTION 1: PATIENT INFORMATION

Fill in the patient's complete name, including any previous name(s)(if applicable), date of birth, address, preferred telephone number, and email address.

SECTION 2: PROVIDER/FACILITY/PERSON INFORMATION

Fill in the name, address, telephone number, fax number, and email address of the individual or organization that you would like QuadMed to disclose your health information to, or obtain your health information from.

NOTE: You must check the appropriate box to indicate whether QuadMed will be ***sending*** or ***requesting*** your health information.

SECTION 3: INFORMATION TO BE DISCLOSED

Check as many boxes as you need to in order to indicate what information should be disclosed or obtained. You may also check "Other" and provide a description of what information should be disclosed or obtained. If all records listed in this section are needed, simply check "Entire Medical Record".

NOTE: You must check the appropriate box(es) if you want any of the following information included in your request (as defined by applicable federal and state law): Alcohol/Substance Use, Developmental Disabilities, Genetics Testing, HIV Test Results/Treatment, Mental Health, Sexually Transmitted or Other Communicable Disease(s)/Treatment.

SECTION 4: DATES OF SERVICE TO BE DISCLOSED

Fill in the beginning and ending dates of service for the information you wish to have disclosed or obtained. If these fields are left blank, information from approximately the last two (2) years will be included.

SECTION 5: PURPOSE OF DISCLOSURE

Check the box or boxes that most closely describe the purpose(s) of the disclosure. If none of the boxes apply, check "Other" and specify the purpose.

SECTION 6: PREFERRED FORMAT/METHOD OF DELIVERY

Select the preferred method of delivery.

SECTION 7: EXPIRATION

Fill in the date you wish this authorization to expire. You may also list a time period or an event. If you leave this field blank, the authorization will automatically expire one (1) year from the signature date in section 9.

SECTION 8: YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

This section explains your rights under the law, and includes a notice that the party receiving your records may not be required by law to keep those records confidential.

SECTION 9: SIGNATURE

Sign your name, print your name, and indicate the date. If you are someone other than the patient, you must complete items (1) and (2), as well as submit appropriate court and/or other official documentation as applicable. If you check “Parent”, and sign this form, you are declaring that you have not been denied physical placement of the minor child by a court of law or had your parental rights terminated by a court order.

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