Noble Community Clinics

Release of Information Authorization (ROI)

MRN:_____
Office use only

1. Patient Information:

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

2. Authorizes:

Noble Community Clinics – All Locations
Address: P.O. Box 1440, Wautoma, WI 54982
Email: medical.records@nobleclinics.org
Phone: 1-800-942-5330 ext. 7039 Fax: 920-765-7017

3. Release my records to:

Name/Organization:_____ Attention:_____

Phone:_____ Fax:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Preferred way to receive information: How should Noble send the completed Release of Information?
☐ via Fax ☐ via Email ☐ via USPS-Mail ☐ Pick up at clinic location: _____

4. Obtain my records from:

Name/Organization:_____ Attention:_____

Phone:_____ Fax:_____

Address:_____

City:_____ State:_____ Zip Code:_____

5. Why is the information needed:

☐ Verify Compliance with Treatment ☐ Worker's Compensation
☐ Personal Use (at my request) ☐ Insurance Eligibility/Payment/Claim
☐ Legal ☐ Transition of Care ☐ Form Completion (FMLA/Disability, etc.)
☐ Health oversight agencies; Judicial/Administrative proceedings; Law enforcement
☐ Other:_____

6. What information do you want released:

A. Service dates:

From (MM/DD/YYYY):_____ To: (MM/DD/YYYY):_____

B. Select the specific records to release:

Complete the Medical, Dental and/or Behavioral Health sections:
All categories do not need to be completed – only check what is needed.

☐ **Medical:** *Primary Care*

☐ History & Physical ☐ Discharge Summary ☐ Progress Notes
☐ Labs ☐ Imaging ☐ Medication Profile
☐ Billing ☐ Immunizations ☐ Referrals & Consults
☐ Vitals ☐ Problem/Diagnosis List ☐ Operations & Procedures
☐ Other:_____

☐ **Dental:**

☐ Progress Notes ☐ Treatment Plan ☐ Imaging (X-Rays)
☐ Perio-Charting ☐ Billing ☐ Medication Profile
☐ Referrals & Consults ☐ Other:_____

B. Select the specific records to release: *Complete the Medical, Dental and/or Behavioral Health sections: All categories do not need to be completed – only check what is needed.*

☐ **Behavioral or Mental Health:** ***Not Including AODA/SUD***

- ☐ Initial Assessment
- ☐ Discharge Summary
- ☐ Referrals & Consults
- ☐ Medication Profile
- ☐ Identify/Presence in Treatment
- ☐ Current Service/Treatment Plan
- ☐ Billing
- ☐ Problem/Diagnosis List
- ☐ Labs
- ☐ Referrals & Consults
- ☐ Other:_____

C. Records Requiring Specific Consent: *The applicable records must be checked in order to be released:*

- ☐ Psychological Testing
- ☐ AODA Treatment/Progress Notes
- ☐ Neuropsychology Notes
- ☐ HIV/AIDS Results
- ☐ Mental Health Treatment/Progress Notes
- ☐ Clinical Updates (School-Based Mental Health)
- ☐ Genetic Testing Results

D. Records Requiring Minor Consent: *Complete this section if you are a minor authorizing disclosure of these protected records. The applicable records must be checked and signed by the minor patient to be released.*

- ☐ Outpatient AODA (12+ yrs)
- ☐ Neuropsychology notes (12+ yrs)
- ☐ Sexually transmitted disease (17+ yrs)
- ☐ Birth control pills (17 yrs or younger)
- ☐ Pregnancy-related care or care of newborn (17 yrs or younger)
- ☐ Outpatient mental health care (14+ yrs)
- ☐ Rape or sexual assault/abuse (12+ yrs)
- ☐ Pregnancy test (17 yrs or younger)
- ☐ HIV/AIDS test result (14+ yrs)

Minor Patient Signature:_____ **Date/Time:**_____

7. When information is needed by: Date information is needed: _____(MM/DD/YY).

We will do our best to accommodate your request, however, please give us 30 days to respond (45 CFR §164.524(b)(2)).

8. Expiration: This authorization is effective for **one year** after the date of signature unless otherwise indicated here: _____ (MM/DD/YY).

Revocation: I understand that I may revoke this authorization at any time by submitting a written request to Noble, HIM Department, P.O. Box 1440, Wautoma, WI 54982. Revocation will not affect disclosures already made in reliance on this authorization.

Redisclosure: I understand that information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA. I also understand that certain sensitive records — including substance use disorder treatment records protected under 42 CFR Part 2 and other records protected by state law — may not be redisclosed without my written permission unless the law allows it.

Right to Refuse/No Condition on Care: I understand that I am not required to sign this authorization, and my treatment, payment, enrollment, or eligibility for benefits will not be affected by my decision.

Right to Withdraw: I may withdraw this authorization at any time by providing written notice. I understand that my withdrawal will not affect uses or disclosures already made in reliance on this authorization.

Right to a Copy: I understand that I have the right to receive a copy of this signed authorization.

Patient's (Name Printed): _____

Patient Signature:_____ Date/Time:_____

Authorized Person's Name (Printed): _____

Authorized Person's Signature:_____ Date/Time:_____

Relationship to Patient: _____ ☐ Parent of Minor ☐ Court appointed guardian, **include legal documentation.**