Noble Community Clinics

Release of Information Authorization (ROI)

MRN:_____
Office use only

Patient Information:

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

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. 9015
Fax: 920-765-7017

☐ **To release my records to:**

AND/OR

☐ **To obtain records from:**

Name/Organization:_____ Attention:_____

Phone:_____ Fax/Email:_____

Address:_____

City:_____ State:_____ Zip Code:_____

How you want to receive the information:
Check all that apply

☐ Physical records (copies of documents).
☐ Verbal communication with provider/staff.
☐ Email communication with provider/staff.
Examples of verbal or email communication requests may include verification of treatment engagement, attendance, or status updates.

How would you like Noble to share this information? (check one):
☐ Verbal communication ☐ Email ☐ Fax ☐ USPS Mail
☐ Pick up at clinic location: _____

Why the information is needed:

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

What information do you want released:

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

Select the specific records to release: *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:_____

☐ Behavioral or Mental Health: *Not Including AODA/SUD*
☐ Initial Assessment ☐ Current Service/Treatment Plan ☐ Discharge Summary
☐ Progress notes ☐ Referrals & Consults ☐ Problem/Diagnosis List
☐ Medication Profile ☐ Labs ☐ Other:_____

Records Requiring Specific Consent:

Some types of health information have extra protections under Wisconsin and federal law. We can only release these records if you specifically authorize them. Please check each type of record you want released:

- ☐ HIV-related information (HIV test results, diagnosis, treatment, and care)
- ☐ Sexually Transmitted Infection (STI) Records
- ☐ Substance Use Disorder / Alcohol and Other Drug Abuse (SUD/AODA) Records
- ☐ Developmental Disability Service Records

Dates of service to be disclosed: From (MM/DD/YYYY)_____To (MM/DD/YYYY)_____

Unless otherwise specified below, only records within the categories selected above and for the date range identified may be disclosed, including but not limited to:

- Progress notes
- Treatment records
- Assessments and evaluations
- Discharge summaries
- Laboratory results
- Medication profiles
- Problem lists and diagnoses
- Identification/presence in treatment records
- Any other related records

Limitations or Exclusions (if any):

_____

Records Requiring Minor Consent:

Under Wisconsin law, certain records of minor patients cannot be released without the minor's authorization. Complete this section if any of the following records are requested and the minor is the age indicated.

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

Minor Patient Signature:_____ Date/Time:_____

When information is needed:

Date information is needed: _____(MM/DD/YYYY).

Requests are generally be processed within 30 days of receipt.
If additional time is needed, we will provide written notice as permitted by applicable law.

Expiration:

Expiration Date (optional): _____ (MM/DD/YYYY)

If no expiration date is provided, this authorization will expire one (1) year from the date it is signed.

Patient Rights and Acknowledgements

Revocation of Authorization: I understand that I may revoke this authorization at any time by submitting a written request to Noble Health Information Management (HIM) Department. 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. Certain records, including Substance Use Disorder treatment records protected under 42 CFR Part 2 and records protected by state law, may not be redisclosed without additional authorization except as otherwise permitted by law.

Right to Refuse/No Condition on Care: I understand that signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign 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:_____

(If applicable) Authorized Representative's Name (Printed): _____

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

Relationship to Patient: ☐ Parent of Minor ☐ Court-Appointed Guardian (legal documentation required)

☐ Other:_____ Authority to Act for Patient (attach documentation if required)