

TIMOTHY P. CRAWFORD, S.C.
Your Asset Protection Law Firm

Greater Milwaukee Area Offices:

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TIMOTHY P. CRAWFORD, CELA*, CPA, CAP**
*Board Member of the National Academy
of Elder Law Attorneys*
**Certified Elder Law Attorney*
Certified Public Accountant
***Member of the Council of
Advanced Practitioners*

Michelle M. LaCount – Of Counsel

Lynn M. Vassh – Senior Legal Secretary
Samantha A. Heft – Senior Legal Assistant
Ellen J. Ison – Legal Assistant
Nina M. Manbeck – Legal Assistant
Kay M. Tobias – Legal Assistant
Tami L. Beaugrand – Marketing Coordinator
Heather R. Pollock – Marketing Assistant
Shrona T. Barry – Receptionist

MEDICAL INFORMATION RELEASE

INSTRUCTIONS TO CLIENT

I would strongly encourage you to complete the attached “*Medical Information Release*” form. Every one you know should complete one of these forms. The form I have supplied to you is from a local hospital. Generally one hospital/doctor will accept the other hospital/doctor’s form. If not, you will know it at the time you try to turn it in. After you have shown them this form and they refuse to accept it because it is not “their form”, then you can ask them for their form. Many hospital/doctor workers are unaware of the correct form to be used. This is a form where you are trying to authorize a loved one to obtain medical information from the hospital/doctor while you are alive and competent.

This package is being given to you free of charge by Attorney Timothy P. Crawford.

This is a free client service.

TPC/kmw/DATA-TPC/POA/MEDICAL INFORMATION RELEASE COVER LETTER/042511

GREATER MILWAUKEE AREA OFFICES IN BROOKFIELD, GLENDALE, MILWAUKEE & RACINE



* Attorney Timothy P. Crawford has been Nationally Board Certified as an Elder Law Attorney by The National Elder Law Foundation which has been Approved as the Sole Certifying Organization for Elder Law Attorneys by The American Bar Association.

MEDICAL INFORMATION RELEASE

What do you have to do to have a loved one find out about your medical condition.

I have enclosed a document that All Saints Healthcare uses entitled "*Designation of Personal Representative*". This document concerns consenting to the release of medical information and has nothing to do with the Personal Representative that you may name under your Will at death. The form is authorized by Federal and State laws.

The form is self explanatory and easy to use. I would recommend that you complete this form and then take it to your hospital.

Your hospital may want it's own form completed. If so, then complete their form.

- You should do the same at your doctor's office.
- You should do the same at your dentist's office.
- You should do the same at any other medical professional's office that you use.

Each office may have their own form.

This has been provided to you free of charge.

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I have attached 2 standard HIPAA Release forms for your use if you so desire. With a HIPAA Release form, you can authorize a person to receive information from your health care professionals. You can authorize more than one person to receive this information. Use a separate form for each person you want to authorize.

This person, under the HIPAA Release Law, is called a Personal Representative. They are representing you personally in your medical area. This form gives them no authority to make decisions. That can only be done with a Health Care Power of Attorney. A separate document. A Health Care Power of Attorney is only activated and useable when you are incompetent.

I am providing this information and these forms to you free of charge.

Make sure that if you do sign a form, that you give a copy of that form to your health care professional. Your health care professional will put it into your medical records.

Your health care professional may be unwilling under the law to accept this form. That is their right. If they refuse to accept this form, then ask them for their form. Then complete their form and return it to them.

TPC/Imv/DATA-TPC/POA/HIPAA FORM COVER LETTER/042111

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DESIGNATION OF PERSONAL REPRESENTATIVE

All Saints Healthcare is allowed to communicate regarding your Protected Health Information (PHI) with persons whom you indicate are involved in your healthcare. PHI includes information about your medical condition, diagnosis, treatment and prognosis, as well as billing and payment for services. You are not required to designate a personal representative, but if you wish to designate a personal representative we ask that you do so by completing this authorization form.

A personal representative may be a spouse, relative, domestic partner, or a friend. You may remove or add a personal representative at any time. Your personal representative will have the ability to: make or confirm appointments; receive x-ray, lab or other test results; communicate with your physician or other health care provider regarding your health care; and/or communicate with All Saints regarding billing and payment for services.

A personal representative is not allowed to act on your behalf unless otherwise stipulated in a legally binding Advance Directive (Healthcare Power of Attorney, Living Will) or court approved guardianship. Therefore, this personal representative will not be allowed to make decisions about your healthcare, authorize procedures or authorize any disclosure of your PHI unless such a legally binding document exists or other law supercedes. In order to receive copies of PHI, an authorization form signed by the patient/legal representative will be required.

I understand that the hospital's healthcare team may designate an interim personal representative, if designating a personal representative will expedite or enhance my care as a patient.

<hr/> <i>Patient Name</i>	<hr/> <i>Social Security Number</i>
<hr/> <i>Street Address</i>	<hr/> <i>Date of Birth</i>
<hr/> <i>City, State, Zip</i>	<hr/> <i>Telephone Number</i>

I designate the following as my personal representative or representatives:

<hr/> <i>Name of personal representative</i>	<hr/> <i>Relationship</i>
<hr/> <i>Street Address, if known</i>	<hr/> <i>Telephone Number</i>
<hr/> <i>City, State, Zip</i>	

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<hr/> <i>Street Address, if known</i>	<hr/> <i>Telephone Number</i>
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I understand that this authorization will be effective for the lifetime of the patient unless revoked.

I understand that I may revoke this designation at any time by notifying All Saints in writing; however, if I do revoke the designation, it will not have any effect on any actions taken by All Saints prior to their receipt of the revocation.

I understand that my treatment cannot be conditioned on whether I complete this designation.

<hr/> <i>Signature of Patient or legal representative</i>	<hr/> <i>Date</i>
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If signed by legal representative, Relationship to Patient

Staff instructions: Enter into Eclypsis Initials _____ Date Completed _____
Send to Health Information

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