225000 Hummingbird Rd
Wausau, WI 54401
715.359.6442
Fax 715.393.0390

100 Eagle Drive
Merrill, WI 54452
715.536.7181
Fax 715.393.0390

724 South 8th Street
Medford, WI 54451
715.748.2663
Fax 715.393.0390

1767 Park Avenue
Plover, WI 54467
715.344.1260
Fax 715.393.0390

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. Patient Information

Name – Last, First, MI		
Address – Street Address, City, State, Zip		
Birthdate	Daytime Phone Number	E-mail Address **OR** Alternate Phone Number:

2. Disclosed By:
☐ **Bone & Joint Clinic, SC**
☐ **Bone & Joint Surgery Center**
☐ **Other (Complete box below)**

Name – (e.g. Other Health Facility, Other Physician . . .)	
Address	
City State Zip Code	
Phone No.	**Fax No.**

3. Disclosed To:

Name – (e.g. Patient, Physician, Insurance Co., Lawyer. . .)	
Address	
City State Zip Code	
Phone No.	**Fax No.**

4. INFORMATION TO BE USED OR DISCLOSED: *(Identify below the specific information you are authorizing to be disclosed; check all that apply)*

☐ **Office Notes** ☐ **Operative/Procedure Reports** ☐ **Radiology Reports** ☐ **Radiology Images**
☐ **EMG Reports** ☐ **Lab Reports** ☐ **Return to Work Forms** ☐ **Billing Statements**
☐ **Concussion/ImPACT Reports** ☐ **Other (specify)** ____

(If "all" records is specified, only last 2 years will be provided)

DISCLOSURES REQUIRING SPECIAL CONSENT: In compliance with Wisconsin Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Please initial all that apply.

_____ Drug/Alcohol Abuse/Treatment _____Mental/Behavioral Health Records _____HIV Test Results

FOR THE FOLLOWING DATES OF SERVICE: From:______________________To: ___________________________

Delivery Method Preferred: ☐ **Mail** ☐ **Fax:** __________________________ ☐ **Pick Up:** ________________

☐ **Other:** _____________________________________ ☐ **Paper copies** ☐ **CD/DVD**

5. Purpose or need for disclosure (check all applicable)

☐ **Further Medical Care** ☐ **Disability Determination** ☐ **Changing Physicians**
☐ **Legal Investigation/Action** ☐ **Insurance Eligibility/Benefits** ☐ **Patient Use**
☐ **Other** ____

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Right to Revoke: I understand that I may revoke this authorization in writing at any time, except to the extent that the authorization was acted upon prior to revocation.

Right to Review: I understand that I have the right to inspect and receive a copy of the materials to be disclosed.

Expiration: This authorization is good until the following date________________________ **OR** for one year from the date signed.

I understand that treatment, payment, enrollment in a health plan or eligibility of benefits may not be conditioned on my decision to sign this authorization, except as provided in federal health information privacy laws.

A copy of this authorization is as valid as the original. I understand that I am entitled to receive a copy of this authorization after I sign it.

I have had an opportunity to review and understand the content of this two-sided authorization form. By signing this form, I understand and agree with the content.

____ **Date:** ______________________

Signature of Patient **OR** Person legally authorized to sign for patient

____

Print name of person signing above

<u>If signed by person other than Patient, check reason and authority to do so</u>.

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Legal Authority:

☐ **Parent of Minor** ☐ **Legal Guardian** ☐ **Health Care Agent** ☐ **Spouse of Deceased**
☐ **Personal Representative/Domestic Partner of Deceased**
☐ **Other :** ____

FOR ORGANIZATIONAL USE ONLY	
Date Received:	**Received By:**