

PATIENT:

Name of Patient/Previous Names

Birth Date/Medical Record Number

Street Address

City, State, Zip Code

AUTHORIZES:

Name of Health Care Provider/Plan/Other

**TO RELEASE PROTECTED HEALTH
INFORMATION TO:**

Eau Claire Medical Clinic
703 W. Hamilton Ave.
Eau Claire, WI 54701

Street Address

Physician

City, State, Zip Code

INFORMATION TO BE RELEASED:

- | | | |
|--|---|---|
| <input type="checkbox"/> Medical History, Examination, Reports | <input type="checkbox"/> Surgical Reports | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Treatment or Tests | <input type="checkbox"/> Hospital Records Including Reports | |
| <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Allergy Records | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Consultations | |
| <input type="checkbox"/> Other (Specify): _____ | | |

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Other (Specify): _____ | | |

For the Following Date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

- | | | |
|---|--|--|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Personal | <input type="checkbox"/> Changing Physicians |
| <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Legal Investigation or Action | |
| <input type="checkbox"/> Other (Specify): _____ | | |

I understand that I have the right to:

- Inspect or copy the information to be used or disclosed.
- Receive a copy of this authorization.
- Revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal privacy regulations.

I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

Unless otherwise revoked, this authorization will expire on: _____ or for one year from the date signed.

SIGNATURE OF PATIENT: _____ **DATE:** _____

Signature of personal representative, person authorized By patient, or other legal authority

Relationship/legal authority