

WESTERN WISCONSIN MEDICAL ASSOCIATES, S.C.

FAX TO 715-425-7075

Authorization for Use and Disclosure of Patient Health Information

_____	_____	_____
Name of Patient	Maiden or Previous Name	Birthdate
_____	_____	
Street Address	City, State, Zip	

AUTHORIZE:		RELEASE RECORDS TO:	
_____	_____	_____	_____
Name of Physician/Healthcare Facility	Name of Physician/Healthcare Facility		
_____	_____	_____	_____
Street Address	Street Address		
_____	_____	_____	_____
City, State, Zip	City, State, Zip		
_____	_____	_____	_____
Telephone #	Fax #	Telephone #	Fax #

INFORMATION TO BE RELEASED:

- | | |
|---|---|
| <input type="checkbox"/> Medical history, examination, reports | <input type="checkbox"/> Treatment or tests |
| <input type="checkbox"/> Allergy records | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Surgical reports | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Entire record (of releasing facility only) | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> X-ray reports | <input type="checkbox"/> Prescriptions |
|
<input type="checkbox"/> Other (please specify): _____. | |

For the following date(s): _____.

In compliance with Wisconsin law, which requires 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"/> HIV (AIDS) | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug abuse |
|
<input type="checkbox"/> Other (please specify): _____. | |

For the following date(s): _____.

The use or disclosure (as applicable) is for the following purpose(s):

- | | |
|---|--|
| <input type="checkbox"/> Further medical care | <input type="checkbox"/> Changing physicians |
| <input type="checkbox"/> Insurance benefits/eligibility | <input type="checkbox"/> Personal reasons |
| <input type="checkbox"/> Legal investigation or action | |
| <input type="checkbox"/> Other (please specify): _____. | |

I understand that WWMA will not condition my treatment on whether or not I sign this authorization form, except in the following situations:

- If the medical information to be disclosed will result from treatment for research purposes, WWMA will not provide the treatment if I am unwilling to sign this authorization form.
- If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, WWMA will not provide the treatment if I am unwilling to sign this authorization form.

I understand that I may revoke this authorization by sending a written request for revocation to WWMA's HIS Department Manager. I understand that I may not revoke this authorization during an insurance contestability period or with respect to disclosures that WWMA may have already made in reliance on this authorization. I understand that when WWMA discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

I understand that the disclosure of information under this authorization may result in direct or indirect remuneration to WWMA from a third party.

This authorization expires upon the earlier of _____ or one year from the date below.

I understand and agree to the terms of this authorization:

Patient (or Patient Representative) Signature

Date

Patient's Date of Birth

Day Time Telephone #

If signed by Patient Representative, state authority to act on behalf of patient:

OFFICE USE: PHOTO /IDENTIFICATION VERIFIED: _____ (DATE) _____ (STAFF INITIALS)
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***IF LEAVING OUR CLINIC – REASON: _____ DISATISFACTION _____ MOVING _____ INSURANCE _____ CONVENIENCE OF HOURS _____ CONVENIENCE OF LOCATION
