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New Holstein, WI 53061

Phone: 920-888-2036
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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

This authorization complies with 45 CFR § 164.508(c) (HIPAA)

Patient: _____ **Patient's Date of Birth**: _____

I hereby authorize _____ to furnish, discuss and release all information and records requested below in writing covering findings, treatment rendered, and opinions as to my condition as authorized below to [insert name of person or entity the records will be release to].

Dates of Protected Health Information to be released:

- ☐ from _____ to _____
- ☐ and for the next 12 months or until I revoke this Authorization, whichever comes first.

Purpose of this Authorization to Release Health Care Information:

- ☐ to develop and coordinate my treatment plan
- ☐ to communicate contraindications, precautions, progress and/or recommendations for return to work, athletic/sports activities or other functional activities
- ☐ to pursue legal/liability claims
- ☐ to comply with the patient's request
- ☐ Other: _____

_____

_____

_____

Records authorized to be released:

- ☐ Examination/Evaluation records
- ☐ All treatment records
- ☐ Diagnostic tests (MRI, X-rays, CT Scan, EMG/NCV testing, and any other diagnostic tests) in my records regardless of who created the records.
- ☐ Other: _____

_____

ACKNOWLEDGEMENTS:

- I understand, and voluntarily consent, to disclosure of information to the extent stated above. A copy of this Authorization shall have the same force and effect as the original. Subsequent disclosures may be made under this Authorization.
- The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I may revoke this authorization at any time by executing a written revocation, subject to the rights of any individual who acted in reliance on the authorization prior to receiving notice of revocation. This revocation will be signed and dated by me and will state that all or part of this authorization is revoked.
- Upon my request, I am entitled to a copy of this authorization and to inspect or copy information disclosed hereunder, pursuant to C.F.R. 164.524.
- I understand that no enrollment or eligibility for benefits, treatment or payment is intended or expected to be conditioned upon this Authorization.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian's Signature Date