OAW STAFF INITIALS: _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT LABEL

1. **Patient Information (Please Print):**

   Patient's Legal Name: _____ Date of Birth: _____

   Address: _____

   City: _____ State: _____ Zip: _____ Phone: _____

2. **Please release my records from:** **ORTHOPAEDIC ASSOCIATES OF WI**
   N15 W28300 GOLF ROAD
   PEWAUKEE, WI 53072-4800

3. **Please release my records to:**
   Person, Clinic, or Organization: _____

   Address: _____

   City: _____ State: _____ Zip: _____ Phone: _____

   Fax: _____

4. **Records I would like to release: (*check all that apply*)**

   ☐ Physician Notes
   ☐ Laboratory Reports including Pathology Reports
   ☐ X-Ray/Radiology/ MRI Reports
   ☐ All Diagnostic Tests including EMG & Bone Density
   ☐ Other (*please specify*): _____
   ☐ Operative Reports
   ☐ Therapy Notes
   ☐ Films & CDs
   ☐ Billing Records

5. **Year of Service and/or Part of Body:** _____

6. **Purpose:**
   ☐ Follow-Up Medical Care/ 2nd Opinion
   ☐ Disability/FMLA
   ☐ Legal
   ☐ Personal
   ☐ Insurance
   ☐ Other (*please specify*) _____
   ☐ Worker's Compensation

7. **Release by:**
   ☐ Mail ☐ Pick Up - **Location:** ☐ **Pewaukee** ☐ **Brookfield** ☐ **Mukwonago**
   ☐ Email **E-mail Address:** _____
   ☐ Fax **Fax Number:** _____

8. **Your Rights with Respect to this Authorization:**
   I understand that I have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this authorization form. I understand that if I agree to sign this authorization, I may receive a copy. I understand that I am under no obligation to sign this form and that Orthopaedic Associates of Wisconsin may not condition treatment or payment of claims. I understand that I have the right to revoke this authorization at any time by providing written notice to Orthopaedic Associates of Wisconsin. I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. **Copy of Facsimile (FAX) Valid as an Original.**

9. **Expiration Date:** This authorization will expire on the following date or event: _____. If I do not specify an expiration date or event, this authorization will expire in 6 months.

10. **SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE:** _____ **DATE:** _____
    If signed by a person other than the patient, state relationship (proof may be required): _____
    * Reason patient is unable to sign: ☐ Minor ☐ Deceased ☐ Other: _____

OAW STAFF USE:

Released by: _____ **Number of Pages Released:** _____ **Imaging Disc Released:** ☐ **Yes** ☐ **N/A**

Date Released: _____ **Method Released:** ☐ **Mail** ☐ **Pick Up** ☐ **Fax** ☐ **Email**