INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

PRINT

Patient's Legal Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____ Zip: _____ Phone: _____

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

2. Please release my records to:

Person, Clinic, or Organization: _____

Address: _____

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

Fax: _____

3. 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
- ◻ Operative Reports
- ◻ Therapy Notes
- ◻ Films & CDs
- ◻ Billing Records

◻ Other (*please specify*): _____

4. Year of Service and/or Part of Body: _____

5. Purpose:

- ◻ Follow-Up Medical Care/ 2nd Opinion
- ◻ Insurance
- ◻ Attorney
- ◻ Disability
- ◻ Personal
- ◻ Worker's Compensation
- ◻ Other (*please specify*): _____

6. Release by: ◻ Mail ◻ Pick Up **Location:** ◻ **Pewaukee** ◻ **Brookfield** ◻ **Mukwonago**
◻ Email **Email Address:** _____
◻ Fax **Fax Number**: _____

I authorize the use and/or release of my protected health information as described below:
I understand that the information used or released as a result of this authorization may no longer be protected by the federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization**.** I may refuse to sign this authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this authorization by providing written notice to Orthopaedic Associates of Wisconsin. Revocation of this authorization will not affect any action taken before receipt of the written revocation. 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.

SIGNATURE OF PATIENT: _____

DATE: _____

PERSON AUTHORIZED BY PATIENT TO SIGN (*Proof Required*): _____

DATE: _____

* Reason patient is unable to sign: ◻ Minor ◻ Deceased ◻ Other: _____

STAFF USE:

Released by: _____ Number of Pages Released: _____

Imaging Disc Released: ◻ Yes ◻ N/A Date Released: _____

Method Released: ◻ Mail ◻ Pick Up ◻ Fax ◻ Email