

WILDWOOD FAMILY CLINIC, S.C.
PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

 Patient Name

 Date of Birth

 Street Address

 City, State , Zip Code

AUTHORIZE:

TO RELEASE RECORDS TO:

 Name of physician/other health care provider

 Name of physician/other health care provider

 Street Address

 Street Address

 City, State, Zip Code

 City, State, Zip Code

HEALTH INFORMATION TO BE RELEASED:

- _____ All Medical Records
- _____ Immunization Records
- _____ Lab Reports
- _____ X-Ray Reports

- _____ X-Ray Films - Specify
- _____ Physical Therapy Records
- _____ Billing Reports
- _____ Other (specify below)

FOR THE FOLLOWING DATES:

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

- _____ Mental Health
- _____ Alcoholism
- _____ HIV (AIDS)

- _____ Developmental Disabilities
- _____ Drug Abuse
- _____ Other (specify below)

PURPOSE FOR DISCLOSURE:

- _____ Further Medical Care
- _____ Relocation/Moving
- _____ Changing Physicians
- _____ Insurance Change

- _____ At the request of the patient
- _____ Legal
- _____ Insurance eligibility/benefits
- _____ Other (explain)

EXPIRATION

This authorization will expire on ____ / ____ / _____. If I do not indicate a date, this will expire one (1) year from the date of my signature below.

SIGNATURE

I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

 Signature

 Date

() Parent () Guardian () POA of Health Care () Spouse/ Family Member of deceased patient

