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

Patient Name _____ Date of Birth _____

Street Address _____ City, State , Zip Code _____

AUTHORIZE:

Name of physician/other health care provider _____

Street Address _____

City, State, Zip Code _____

TO RELEASE RECORDS TO:

Name of physician/other health care provider _____

Street Address _____

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 Statues 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

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

ADDITONAL INFORMATION REGARDING RELEASE OF HEALTH INFORMATION

Wildwood Family Clinic recognizes the patient's right of confidentiality of their health information under federal privacy regulations and Wisconsin law. Patients should be aware of the following information when requesting or releasing health information.

- RIGHT TO INSPECT OR COPY THE INFORMATION TO BE USED OR DISCLOSED: I understand I have the right to inspect or copy the heath information used or disclosed by this authorization. I may arrange to inspect my health information by contacting the Wildwood Family Clinic, clinic administrator.

- RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION: I have the right to refuse to sign this authorization and this refusal will not affect my ability to obtain treatment or payment of claims.

- RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION: I understand that I have a right to receive a copy of the signed authorization form.

- REDISCLOSURE OF INFORMATION BY RECIPIENT: I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact Wildwood Family Clinic's privacy officer at (608) 221-1501.

- RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time by giving written notice of revocation to the Wildwood Family Clinic. I understand that the revocation of this authorization will not apply to information that has already been released in response this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

- FEES FOR RECORDS: I understand that the Wildwood Family Clinic may charge a reasonable fee for viewing, copying, postage and preparation of records to fulfill this request. All fees are based on applicable laws governing release of health information.

- WHO MAY SIGN THIS AUTHORIZATION:

    1. All patients 18 years of age and older must sign for release of their own health information unless the following conditions apply:

        a. The patient is incompetent
        b. The patient is disabled and can not sign the form
        c. The patient is deceased. (A surviving spouse or personal representative of the estate may sign. If there is no surviving spouse or personal representative, then an adult member of the immediate family may sign.)

    2. All persons signing for release of health information on behalf of the patient must state their relationship to the patient and provide proof of legal authority of their capacity to act for the patient.

    3. Minors: Patient younger than 18 years of age must sign for release of their health information in the following cases:

        a. Alcohol or other drug abuse treatment: age 12 or older
        b. Mental health treatment: age 14 or older may consent to release records without parental consent (parents also retain the right to access this information.)
        c. HIV test results: age 14 or older
        d. Emancipated minors who are married or in the military