5320 W. Michaels Drive, Appleton, WI 54913

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

Name: _____ Maiden/Other Name: _____

Address _____
Street City State Zip Code

Birth Date: _____ Telephone #: _____

I HEREBY AUTHORIZE:

☐ **NeuroSpine Center of Wisconsin**

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

TO RELEASE RECORDS TO:

☐ **NeuroSpine Center of Wisconsin**

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE RELEASED: *Identify below the specific information you are authorizing to be released.*

☐ Office Notes (Dates) _____
☐ Physical Therapy Notes (Dates) _____
☐ Lab Reports (Dates) _____
☐ Hospital Reports-OP/DS (Dates) _____
☐ Radiology Reports
☐ EMG/NCV/SSEP
☐ Pathology Reports
☐ Other (specify) _____
☐ Work restrictions
☐ Radiology CD's

DISCLOSURE REQUIRING SPECIAL CONSENT: **In compliance with Wisconsin Statutes, which require special permission for release of otherwise privileged information, please release related to the following:**

☐ Mental Health Treatment
☐ AIDS/AIDS related diagnosis
☐ Treatment of Alcohol or Drug Abuse
☐ Developmental disabilities
☐ HIV test Results *

Purpose of Disclosure: *Please provide specific purpose for disclosure or check applicable category.*

☐ Continuing care
☐ Personal Use
☐ Insurance
☐ Workers Compensation
☐ Legal Investigation
☐ Customer Service dissatisfaction (specify) _____
☐ Other (specify) _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed - I understand that I have the right to inspect or receive a copy (with possible fee) of the health information I have authorized to be used or disclosed by this form. **Right to Refuse to Sign this Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. ****Right to Withdraw this Authorization -** I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the Health Information Department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. ***HIV Test Results –** I understand my HIV test results may be released without authorization to persons/organizations that have access under State Law and a list of those persons/organizations is available upon request. ****WI Statutes 51.30 and 252.15** require patient authorization to disclose health information for payment purposes.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good for one year from the date signed or until the following date(s) _____. Records may be released after the date of signature through the expiration date.

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 PATIENT/LEGAL REP.: _____ **DATE:** _____
(If signed by other than patient, state relationship and authority to do so.)

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FOR OFFICE USE ONLY	
Type(s) of information disclosed	**Dates(s) of information disclosed**
❑ Office notes	
❑ Work Restrictions	
❑ Radiology Reports	
❑ X-ray Films	
❑ EMG/NCV/SSEP	
❑ Laboratory reports	
❑ Hospital reports	
❑ Pathology reports	
❑ Other (describe)	
Release Date & Time:	***Total # of pages:***
Initials of employee completing:	