Northeast Wisconsin Retina Associates

Patient Name _____ Account Number _____
Date of Birth _____Phone Number _____
Address_____
City, State, Zip Code _____

I authorize the use and/or disclosure of my protected health information:

FROM:
Name _____
Organization _____
Address _____
City, State, Zip _____
Phone Number _____
Fax Number _____
Secure Email_____

TO:
Name _____
Organization _____
Address _____
City, State, Zip_____
Phone Number _____
Fax Number _____
Secure Email_____

Information to be disclosed includes:

- ☐ All Clinic Records
- ☐ Progress Notes
- ☐ Operative Reports
- ☐ Letters
- ☐ Imaging
- ☐ Labs
- ☐ Other (Specify) _____

Date Range of Service: _____

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

___Mental Health ___Developmental Disabilities ___Alcohol &/or Drug Abuse ___HIV test results

Dates of Service (Specify): _____

Purpose of Disclosure:

- ☐ Medical Care
- ☐ Insurance
- ☐ Legal
- ☐ Changing Providers
- ☐ Personal
- ☐ Disability Determination
- ☐ FMLA
- ☐ Worker's Compensation
- ☐ Law Enforcement
- ☐ Social Services
- ☐ Other (Specify) _____

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Right to Revoke: I understand that I may revoke this authorization in writing at any time, except to the extent that the authorization was acted upon prior to revocation.

Right to Review: I understand I have the right to inspect and receive a copy of the materials to be disclosed.

Expiration: This authorization is effective for one year from the date signed, or on occurrence of the following event: _____

I understand that treatment, payment, enrollment in a health plan or eligibility of benefits may not be conditioned on my decision to sign this authorization, except as provided in federal health information privacy laws.

A copy of the authorization is valid as the original. I understand that I am entitled to a copy of this authorization after I sign it.

Patient Signature_____Date_____

Signature of Parent/Legal Representative _____Date_____