PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in full. See reverse side for important information.)

I. PATIENT INFORMATION

_____ _____
(Name of Patient) (Date of Birth)

_____ _____
(Street Address) (City, State, Zip)

II. AUTHORIZE:

_____ _____
(Name of Physician/Health Care Facility/Other) (Phone/Fax Number)

_____ _____
(Street Address) (City, State, Zip)

III. TO RELEASE PROTECTED HEALTH INFORMATION TO:

Community Pediatrics, SC — 920-885-3305/920-885-5506
(Name of Physician/Health Care Facility/Other) (Phone/Fax Number)

109 Warren Street, Suite 4 — Beaver Dam, WI 53916
(Street Address) (City, State, Zip)

IV. HEALTH INFORMATION TO BE RELEASED:

_____ All Medical Records from _____
_____ Immunization Records/Growth Chart
_____ Lab Reports
_____ X-Ray Reports
_____ X-Ray Films – Specify
_____ Billing Records – Specify
_____ Other

A. 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 _____

V. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

____ Further Medical Care
____ Insurance Eligibility/benefits
____ Disability determination
____ At request of Patient
____ Legal Investigation
____ Other _____
_____ Vocational rehabilitation evaluation

VI. EXPIRATION

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

VII. SIGNATURE

I have had full opportunity to read and consider the contents of this Authorization that the health care provider my use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this Authorization is signed by a representative on behalf of this patient, complete the following:
Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION.

Additional Information Regarding Release of Health Information

Community Pediatrics, SC recognizes the patient's right of confidentiality of their health information under federal privacy regulations and Wisconsin Law. The patient should be aware of the following information when requesting or releasing health information.

- **Right to refuse to sign this authorization**: A patient may refuse to sign this Authorization and this refusal will not affect the patient's ability to obtain treatment or payment of claims.
- **Right to inspect or copy the health information to be used of disclosed**: A patient has the right to inspect or copy the health information they have authorized to be used or disclosed by signing this Authorization form. A patient may arrange to inspect their health information by contacting this office directly.
- **Right to receive copy of this authorization**: A patient has the right to receive a copy of the signed Authorization form.
- **Right to revoke this authorization**: A patient has the right to revoke this Authorization at any time by giving written notice of revocation to the Office Manager listed below. Revocation of this Authorization will not affect any action taken in reliance of this authorization before receipt of the written notice of revocation.
- **Multiple releases of Information**: A patient may request multiple releases of the information stated on the Authorization form. However, all releases based on this form are limited to the records dated up to and including the date of patient's signature. A new Authorization is necessary for release of information for care provided after the date of the patient's signature, unless the Authorization specifically states that specific records that will be generated in the future maybe be released, for example "future records of a specific test" or "future records of specific clinic appointment."
- **Who may sign this Authorization**:
  1. Generally, all patients 18 years 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 cannot 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 legal authority of their capacity to act for the patient.
  3. Minors: Patients less 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 of records without parental consent (Parents also retain the right to access this information.)
     c. HIV test results: 14 or older.
     d. Emancipated minors who are married or in the military.
- **Fees for records:** Community Pediatrics, SC, may charge a reasonable fee for viewing, copying, postage and preparation of records to fulfill this request. All fees are based on the applicable laws governing the release of health information.
- **Contact Office:** Community Pediatrics, SC, Office Manager, 109 Warren Street, Suite 4, Beaver Dam, WI 53916 Telephone: 920-885-3305