Phone: 920.729.7105
Fax: 920.720.2150
www.womenscareofwi.com

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO WOMEN'S CARE OF WISCONSIN

1. PATIENT:

_______________________________ _______________________________
Name of Patient/Previous Names *Birth Date*

_______________________________ _______________________________
Street Address *City, State, Zip Code*

2. AUTHORIZES:

____
Name/Organization

____
Street Address

____
City, State, Zip Code

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Women's Care of Wisconsin
200 Theda Clark Medical Plaza, Suite 130
Neenah, WI 54956

3. Information to be released:

	Date of Service		Date of Service
❑ Progress Notes	____________	❑ Discharge Summary	____________
❑ Ultrasound	____________	❑ Operative/Procedure Report	____________
❑ OB/ACOG	____________	❑ Physical Therapy	____________
❑ History and Physical	____________	❑ Labs	____________
❑ Pathology/Lab Report	____________	❑ X-ray/EKG/Ultrasound	____________
❑ Consultations	____________	❑ Other ______________________	
❑ Immunizations	____________	❑ Past 2 years	____________

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

❑ Alcohol Abuse or test results
❑ Drug Abuse or test results
❑ Mental Health
❑ HIV test results, AIDS or AIDS-Related disease
❑ Sexually Transmitted Diseases

5. This disclosure is being made for the following purpose(s):

❑ Further medical Care
❑ Relocation/Moving
❑ Insurance Change
❑ At the request of an individual
❑ Work Comp
❑ Attorney/Court Case
❑ Insurance
❑ Other (comments) ______________________
❑ Changing Physicians (explain) ____

____

Signature of patient

Date

Signature of personal representative, person authorized by the patient, or legal authority

Relationship or legal authority