Women's Care OF WISCONSIN, S.C.

**Phone: (920) 729-7105**
**Toll Free: (877) 729-7105**
**Fax: 920-720-2150**
**www.womenscareofwi.com**

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**1. PATIENT:**

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

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

**2. AUTHORIZES:**

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

**3. RELEASE OF PROTECTED HEALTH INFORMATION TO:**

_____
*Name/Organization/Spouse/Significant Other*

_____
*Street Address*

_____
*City, State, Zip Code*

**4. 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 | _____ | ❑ Semen Analysis | _____ |
| ❑ Immunizations | _____ | ❑ Past 2 years | _____ |
| ❑ Other _____ | | ❑ Results via phone to 3rd party | _____ |

**5. 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

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

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

_____

**Right to Inspect or Copy the Information to be Used or Disclosed**
I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact WCOW's Compliance Officer.

**Right to Receive a Copy of this Authorization**
I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization.

**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 WCOW's Compliance Officer at:

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Neenah, WI 54956
Phone: (920) 729-7105
Toll Free: (877) 729-7105
Fax: (920) 720-2150

**Right to Revoke Authorization**
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to WCOW. I understand that the revocation will not apply to information that has already been released in response to 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.

I understand that if WCOW uses this authorization for marketing activities, I will be informed if they receive any direct or indirect remuneration related to the use or disclosure of my protected health information.

Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____

**Prohibition of Conditions**
WCOW may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

_____ _____
*Signature of patient* *Date*

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

**Medical Records Policy**
Women's Care of Wisconsin will supply you with one copy of your medical records at no cost to you. If you would like to obtain a second copy of records the service fee will be $0.35 per page. Please allow approximately 2 weeks for your medical records to be mailed to the requested party. In case of an emergent request, please speak with the medical records clerk in the Neenah location of Women's Care of Wisconsin.