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

PATIENT:

____
Name of Patient/Previous Names

____
Birth Date

____
Street Address

____
City, State, Zip Code

AUTHORIZES:

____
Name/Organization/Spouse/Significant Other

____
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

INFO TO BE RELEASED:	Date of Service
❑ Progress Notes	__________
❑ Ultrasound	__________
❑ OB/ACOG	__________
❑ History and Physical	__________
❑ Pathology/Lab Report	__________
❑ Consultations	__________
❑ Immunizations	__________
❑ Discharge Summary	__________
❑ Operative/Procedure Report	__________
❑ Physical Therapy	__________
❑ Labs	__________
❑ X-ray/EKG/Ultrasound	__________
❑ Past 2 Years	__________
❑ Other ________________________________	

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

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 ____

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:

200 Theda Clark Medical Plaza, Suite 130
Neenah, WI 54956
Phone: 920.729.7105
Fax: 920.720.2150

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.

____ Date _____/_____/__________
Signature of Patient

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