ORTHOPAEDIC ASSOCIATES
OF WAUSAU

Patient Request for Authorization for Release of Medical Information

Not to be used for Orthopaedic Associates of Wausau use or disclosure for its own purposes
(Please complete in full)

1. Patient Name:_____
(Last, First, MI)
Date of Birth: _____ Social Security: _____

2. Records Release From:

_____
(Name of Doctor/Clinic/Program)
_____
(Street Address)
_____
(City) (State) (ZIP)

3. Records Released to:

_____
(Name of Doctor/Clinic/Program)
_____
(Street Address)
_____
(City) (State) (ZIP)

4. Date of Service: _____

5. Type of Information to be release: *(Check all that apply)*

☐ Medical History ☐ X-ray (Films) ☐ Doctor's Notes ☐ ALL
☐ Surgical Reports ☐ X-ray (Reports) ☐ Lab Results

Any other specific information to be released, please give a meaningful description or explanation:

_____
_____

6. Purpose of release: *(Fees may apply)*

☐ Continuing Care ☐ Insurance Application / Claim ☐ Worker's Comp
☐ Personal / Other _____

7. Special Instructions:

☐ Mail ☐ Patient will pick up ☐ Email:_____ ☐ For appointment on: _____

(We will not fax records unless it is an emergency and have verification of the fax number.)

I authorize Orthopaedic Associates of Wausau to release information as described above. I understand that this authorization is voluntary. I may revoke this authorization by providing my revocation in writing using the **Orthopaedic Associates of Wausau Revocation of Authorization** form so long as Orthopaedic Associates of Wausau has not yet relied upon and/or acted upon my authorization. I understand that I do not have the right to revoke this authorization if it was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim under the policy. I understand that information used of disclosed as a result of this may no longer be protected by federal privacy laws and may be further used or re-disclosed by persons or organizations receiving it.

I understand that if I Agree, Orthopaedic Associates of Wausau may choose to provide a summary or explanation of the requested protected health information. I also understand that Orthopaedic Associates of Wausau may charge a fee for this summary/explanation. **I also understand that Orthopaedic Associates of Wausau has the right to impose a reasonable, cost-based fee for copying, postage and preparation of records associated with fulfilling this request.**

This authorization will be effective for medical records generated by Orthopaedic Associates of Wausau to the date of signature and created or prepared during the effective period of the release. By signing this Authorization for Release, I am authorizing the release of all Orthopaedic Associates of Wausau records applicable to this request that are in my medical record file.

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

_____ _____
(Signature of Patient) Date

_____ _____
And when applicable signature of: Date

☐ Parent of Legal Guardian
☐ Next of Kin of Deceased
☐ Power of Attorney