



ORTHOPAEDIC ASSOCIATES
OF WAUSAU

**Orthopaedic Associates of Wausau
3200 Westhill Drive Suite 201
Wausau, WI 54401-4707**

(Telephone 715-847-2382 or 877-260-6755 Fax 715-847-2381)

**Patient Request for Release of Medical Information
To Orthopaedic Associates of Wausau**

(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:**

Orthopaedic Associates of Wausau

(Name of Doctor/Clinic/Program)

3200 Westhill Drive Suite 201

(Street Address)

Wausau, WI 54401-4707

(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:

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

I authorize (clinic or provider name) _____ to release information as described above. I understand that this authorization is voluntary. I may revoke this authorization by providing my revocation in writing.

I understand that (clinic or provider name) _____ may charge a fee for copies of these records. **I also understand that generating facility has the right to impose a reasonable, cost-based fee for copying, postage and preparation of records associated with fulfilling this request and I will be responsible for any associated fees.**

This authorization will be effective for medical records generated by (clinic or provider name) _____ 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 requested records to Orthopaedic Associates of Wausau.

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)

And when applicable signature of:

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