ORTHOPAEDIC ASSOCIATES
OF WAUSAU

Orthopaedic Associates of Wausau
3901 Stewart Avenue
Wausau, WI 54401-3948
(Telephone: 715-907-0900 | Toll Free: 800-260-6755 | Fax: 715-803-6977)

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)
3901 Stewart Avenue
(Street Address)
Wausau, WI 54401-3948
(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