



Orthopaedic Associates of Wausau
3901 Stewart Avenue
Wausau, WI 54401-3948

(Telephone 715-907-0900 or 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) (Prior/Other Name:)

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(s) 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

I authorize the above clinic or provider to release information as described above. I understand that this authorization is voluntary and I may revoke this authorization by providing my revocation in writing. I understand that information used or 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.

This authorization will be effective for medical records generated by clinic or provider 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)

Date

And when applicable signature of:

Date

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