Eau Claire Women's and Family Care, OB-GYN Clinic of Eau Claire
Divisions of Oakleaf Clinics S.C.
(715)834-9998
(715)834-9833 (Fax)


# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**PATIENT:**

_______________________________________________ _____________ _____________________
*Patient Name/Previous Name(s)* *Date of Birth* *Phone Number*

_______________________________________________ _________________________________
*Street Address* *City, State, Zip Code*

**AUTHORIZES FROM:**

_______________________________________
*Name of Health Care Provider/Plan/Other*

_______________________________________
*Street Address*

_______________________________________
*City, State, Zip Code*

**RELEASE OF PROTECTED INFORMATION TO:**

_______________________________________
*Name of Health Care Provider/Plan/Other*

_______________________________________
*Street Address*

_______________________________________
*City, State, Zip Code*

For the following dates: ___/___/___ to ___/___/___

**INFORMATION TO BE RELEASED:**

______Medical History, Examination, Reports ______ Surgical Reports ______ Immunizations ______ Treatment or Tests

______Hospital Records/Reports ______Radiology Reports ______ Laboratory Reports ______Consultations

______ Other ____________________________________________________________________________

In compliance with Wisconsin Statutes, to release privileged information; Please release records pertaining to:

______Mental Health ______Developmental Disabilities ______ Alcoholism

______HIV (AIDS) ______Sexually Transmitted Disease ______Drug Abuse

**PURPOSE OF DISCLOSURE:**

______Further Medical Treatment ______ Legal Investigation/Action ______Personal

______Insurance Eligibility/Benefits ______Changing Physicians ______Other ___________________

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

*Right to Inspect or Copy the Health Information to be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Oakleaf Clinic, SC. Right to Receive Copy of this Authorization – I understand that if I agree to sign this authorization, which I am not required to do, I may be provided with a signed copy of the form. Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Oakleaf Clinics, SC. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that a person(s) and/or organization(s) listed above have already made in reference to this authorization.*

**EXPIRATION DATE:** This authorization is good until the following date(s) ____________________ or for six months from the date signed.

I understand the content of this authorization form and confirm that it accurately reflects my wishes.

_______________________________________________ ______________________________
*Signature of Patient or Legal Representative/Relationship* *Date*

_______________________________________________
*Witness*