OakLeaf CLINICS PEDIATRICS

A Division of OakLeaf Clinics, SC

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

_____ _____

Patient Name/Previous Name(s) *Date of Birth*

_____ _____

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