CHIPPEWA VALLEY ORTHOPEDICS AND SPORTS MEDICINE
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

_____ Name of Patient

_____ Birth Date

_____ Street Address

_____ City, State, WI, Zip Code

_____ Phone Number

I hereby authorize:

_____ Name

_____ Street Address

_____ City, State, WI, Zip Code

_____ Phone number Fax number

To disclose my protected health Information, as described below, to:

_____ Name of Individual or Entity

_____ Street Address

_____ City, State, WI, Zip Code

_____ Phone number Fax number

Information to be released:

____Medical History, Examination Reports
____Surgical Reports
____X-ray Reports
_____X-ray images
_____Other

***Please specify what you are needing (dates of service, body part that was examined, etc.)**
_____

Purpose of the use or disclosure:

____ At the request of the individual

____Other (Please specify) _____

I understand that I have the right to:

- Inspect or copy the information to be used or disclosed.
- Receive a copy of this authorization
- Revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to the authorization

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal privacy regulations.
I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

Unless otherwise revoked, this authorization will expire on: _____

_____ Signature of patient

_____ Date

_____ Signature of personal representative, person authorized by the patient, or other legal authority

_____ Relationship/legal authority