



Bone & Joint Health Information Department
400 Westwood Drive, Wausau WI 54401
715-359-6442 ext. 1404
Fax: 608-229-1299

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NAME: _____ DOB: _____ Phone: _____

ADDRESS: _____

EMAIL: _____

I hereby request and authorize Bone & Joint Clinic, S.C. and/or Bone & Joint Surgery Center

To: [] Disclose to [] Receive from [] Exchange with

(Name of person, physician, insurance company, attorney's office, other health care facility, etc.)

(Address) (Telephone Number) (Fax Number)

FOR THE FOLLOWING DATES OF SERVICE

Use the line below if completing this form for FMLA/Disability:

FROM: _____ TO: End of Claim

Use the line below for all other requests:

FROM: _____

INFORMATION TO BE USED OR DISCLOSED

- Office Notes, Radiology Reports, Billing Statement, EMG Reports, Return to Work Forms, Lab Reports, Operative/Procedure Reports, PT/OT Records, Psych Consult, Imaging (Pictures)

Other (specify) _____

(If all records are specified, only last 2 years will be provided)

DISCLOSURES REQUIRING SPECIAL CONSENT In compliance with Wisconsin Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed.

- **Please initial all that apply.**

____ Drug/Alcohol Abuse Treatment ____ Mental/Behavioral Health Records
____ HIV Results

PURPOSE FOR DISCLOSURE (Check all that apply)

Continued Care Disability/FMLA Determination Insurance Eligibility/Benefits
 Legal Patient Use Other (Specify) _____

DELIVERY METHOD PREFERRED:

Mail Fax Pick up (Specify location) _____ Email

Preferred format for imaging: Paper copies CD/DVD

HIPAA DISCLOSURE STATEMENTS

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization – I understand that I am entitled to receive a copy of this authorization after I sign it.

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that Bone & Joint Clinic, S.C. and/or Bone & Joint Surgery Center may not condition treatment, payment, enrollment in a health care plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Bone & Joint. I am aware that my withdrawal will not be effective until received by the Health Information Department and will not be effective regarding the uses and/or disclosures of my health information that Bone & Joint has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy (may be provided at a reasonable fee) 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 the Health Information Department at Bone & Joint.

REDISCLASURE NOTICE - I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION: This authorization is good for one year from the date signed.

Signature of Patient **OR** Person legally authorized to sign for patient. Date: _____

Printed Name of person signing above

Electronic Signature Authorization: I acknowledge and agree that my electronic signature above has the same legal effect and validity as my written signature and that this Agreement is valid and will be given the same legal effect as a written and signed Agreement. I further acknowledge and agree that no certification authority or other third-party verification is necessary to validate my electronic signature. My consent to the electronic signature above applies only to this agreement.

If signed by person other than the Patient, check reason and authority to do so:

Patient is: Minor Incompetent/Incapacitated Deceased

Legal Authority: Parent of Minor Legal Guardian Health Care Agent/POA

Spouse/Domestic Partner/Personal Representative of Deceased

Other: _____