OAW STAFF INITIALS: _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT LABEL

1. Patient Information (Please Print):

Patient's Legal Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

2. Please release my records from: **ORTHOPAEDIC ASSOCIATES OF WI**
N15 W28300 GOLF ROAD
PEWAUKEE, WI 53072-4800

3. Please release my records to:
Person, Clinic, or Organization: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Fax: _____

4. Records I would like to release: (*check all that apply)*

☐ Physician Notes
☐ Laboratory Reports including Pathology Reports
☐ X-Ray/Radiology/ MRI Reports
☐ All Diagnostic Tests including EMG & Bone Density
☐ Other (*please specify*): _____
☐ Operative Reports
☐ Therapy Notes
☐ Films & CDs
☐ Billing Records

5. Year of Service and/or Part of Body: _____

6. Purpose:
☐ Follow-Up Medical Care/ 2nd Opinion
☐ Disability/FMLA
☐ Legal
☐ Personal
☐ Insurance
☐ Other (*please specify*) _____
☐ Worker's Compensation

7. Release by:
☐ Mail ☐ Pick Up - **Location:** ☐ **Pewaukee** ☐ **Brookfield** ☐ **Mukwonago**
☐ Email **E-mail Address:** _____
☐ Fax **Fax Number:** _____

8. Your Rights with Respect to this Authorization:
I understand that I have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this authorization form. I understand that if I agree to sign this authorization, I may receive a copy. I understand that I am under no obligation to sign this form and that Orthopaedic Associates of Wisconsin may not condition treatment or payment of claims. I understand that I have the right to revoke this authorization at any time by providing written notice to Orthopaedic Associates of Wisconsin. I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. **Copy of Facsimile (FAX) Valid as an Original.**

9. Expiration Date: This authorization will expire on the following date or event: _____. If I do not specify an expiration date or event, this authorization will expire in 6 months.

10. SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: _____ **DATE:** _____
If signed by a person other than the patient, state relationship (proof may be required): _____
* Reason patient is unable to sign: ☐ Minor ☐ Deceased ☐ Other: _____

OAW STAFF USE:

Released by: _____ Number of Pages Released: _____ Imaging Disc Released: ☐ Yes ☐ N/A

Date Released: _____ Method Released: ☐ Mail ☐ Pick Up ☐ Fax ☐ Email