Women's Health Specialists, S.C.
THE FOX VALLEY OB/GYN PHYSICIANS℠

Appleton Fax: 920-749-4015
Neenah Fax: 920-729-2512

MEDICAL RECORD RELEASE
Authorization for Disclosure of Health Information

______________________________ ______/______/______
Name of Patient Date of Birth

______________________________ ______________________________
Street Address City, State, Zip Code

I hereby authorize:

____
Name of Individual or Entity

____
Street Address

____
City, State, Zip Code

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

____
Name of Individual or Entity

____
Street Address

____
City, State, Zip Code

Information to be released:
☐ Medical History ☐ Treatment/Tests ☐ Laboratory Reports
☐ Office Notes/Examination Reports ☐ Ultrasound Reports ☐ Sexually Transmitted Disease Results
☐ Consultations ☐ Hospital/Surgical Reports ☐ HIV Test Results (A listing of the statutory exceptions to release HIV test results without consent is available)
☐ Other: ______________________________

Purpose for need of disclosure:
☐ Further Medical Care/Changing Doctors ☐ Payment of Insurance Claim ☐ Legal Investigation
☐ Second Opinion ☐ Application for Insurance ☐ Disability Determination
☐ At the Request of the Individual ☐ Other: ______________________________

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without my authorization.

I understand that I have the right to:
- **Receive a Copy of This Authorization.**
- **Refuse to Sign This Authorization**; and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke This Authorization**, except to the extent that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s): ____________________, or event: _________________

______________________________ ______/______/______
Signature of Patient (or Legal Representative) **Date**

Medical Record Release – Rev. 11/12