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

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

_____ _____/_____/_____
Name of Patient Date of Birth

_____ _____
Street Address City, State, Zip Code

I hereby authorize:

_____
Name

_____
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

Other: _____

*A listing of the statutory exceptions to release HIV test results without consent is available)

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: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed

_____ _____/_____/_____
Signature of Patient (or Legal Representative) **Date**
No signature stamps or electronic signatures accepted

www.FoxValleyOBGYN.com
Appleton 920-749-4000 | Neenah 920-729-2510
Appleton Fax: 920-749-4015 | Neenah Fax: 920-729-2512
Jeffery Cherney, MD | Jill Honkamp, MD | Kelly Kennedy, MD I Julie Meyer, DO IJames O'Leary, MD | Elina Pfaffenbach, MD | Tina Ramsey, MD | Amy Schmidt, MD
Connie Masak, APNP | Wanda Vander Wyst, PA-C
Consultant in Perinatology – C.Danae Steele, MD, PhD