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

Patient Information

Name:			Date of Birth:
Address:			Phone:
City:	State:	Zip:	Fax:

I hereby authorize and request **Women's Health Specialists** to:

□ Release Information To: □ Obtain Information From:

Organization:			Contact Name:
Address:			Phone:
City:	State:	Zip:	Fax:

Information to be released:

□ Medical History
□ Office Notes/Examination Reports
□ Consultations
□ Billing/Financial
□ All of the above
□ Treatment/Tests
□ Ultrasound Reports
□ Hospital/Surgical Reports
□ Laboratory Reports
□ Sexually Transmitted Disease Results
□ 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
□ Second Opinion
□ At the Request of the Individual
□ Payment of Insurance Claim
□ Application for Insurance
□ Other: _____
□ Legal Investigation
□ Disability Determination

By signing this authorization, I acknowledge that I have read the reverse side and I release the above organization(s) and/or person(s) from legal responsibilities or liability that may arise from this act.

I understand that this authorization is in effect for one year or until _____ unless otherwise revoked through written notice and except to the extent that the person(s) and/or organization(s) listed above have already made reference to this authorization.

Signature of Patient: _____ Date: _____

Printed Name of Authorized Person: _____

Signature of Authorized Person: _____ Date: _____
Relationship to Patient: _____

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ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Women's Health Specialists honor a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Right to receive a copy of this authorization: You have the right to request a copy of this authorization. You may request the copy from your physician or our front desk.

No Obligation to Sign: You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, Women's Health Specialists may not refuse to provide you treatment or other health care services if you refuse to sign this form. However, if you refuse to release this information by signing the form, it could result in a failure, for example, to properly coordinate your treatment with other health care providers.

Revocation: you have the right to revoke this authorization, in writing, at any time before it expires. However, your written revocation will NOT affect any disclosures of your medical information that the person(s) and/or organization listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to: Women's Health Specialists, 1818 N. Meade St, Suite 330, Appleton, WI 54911.

Re-release: If the person(s) and/or organization authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect: You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact your physician or the office of Women's Health Specialists. In accordance with Wisconsin Stature 51.30 [Patient Access s.51.30(4)(d)3], inspection of a record shall be done with a physician present.

Copying Fees: If you are requesting disclosure/release of medical information to other hospitals, clinics, or physicians for further medical care, no copying fees will be charged. You may be charged for copies you request for other purposes.

Signatures: Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. I you are under the age of 18, your parent or guardian must sign this form for you. There are, however, many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact Women's Health Specialists at 920-749-4000.