

Authorization for Release of Patient-Identifiable Health Information

		b	irthdate/		_/	
By completing the nine in a state of the sta	numbered sections below d.	, I authoriz	e the use or disc	losure	of the above-nar	ned individual's health
To be released by:			② To be re	eleased	to:	
			<u>PRAIRII</u>	E CLIN	NC SC	
ame of physician / health ca	re facility		name			
reet address			112 Hel			
neet audiess						
ity / state / zip				-	53583	ph:608-643-335 fx: 608-643-816
ity / state / zip		_	city / state	·		_
Purpose of disclosure:	☐ Other (specify purpose) _		on for insurance	∐ Le	gal Investigation	Self (personal use)
) Describe the type of info	ormation to be used or disclo	sed. R	ecords from the time	e period:		_ to
Information requested:	☐ All records (or specify) ☐ Allergy Records	☐ Clinic vis		•	☐Consultations ☐ Other (specify)	☐ Immunization records
)In compliance with WI S	tatutes, the following inform	ation will no	he released unles	s hoy is	checked:	
			be released unies	S DOX IS		
☐ One year from t	☐ Alcohol &/or Dro	ug abuse bire: d.	☐ Develop	event or	disability	HIV test results.
Unless otherwise revoke One year from t Format for records: Patient Rights I understand that I h	ed, this authorization will explanation will explanation is signed. Paper DVD Other nave the right to inspect or cop	ug abuse bire: d. □ On y the informa	☐ Develope the following date, € (Note: If formate tion used or disclose	event or eis not se	conditionlected, records will be authorization.	pe released in paper format.)
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Authorization for Release of Patient-Identifiable Health Information

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		birthdat	e/_		/		
By completing the nine information as described. 1) To be released by:	numbered sections belov d.	v, I authorize the	use or discl			ned indiv	idual's health
PRAIRIE CLINIC SC name of physician / health ca			name				
	•						
112 Helen Street street address			street addre				
			01.001.001				
Sauk City, WI 53583							
city / state / zip	fx: 608-643	-8162	city / state / :	zip			
3 Purpose of disclosure:	☐ Further medical care ☐ Other (specify purpose) _	Application for		ŭ	Investigation	☐ Self (p	ersonal use)
Describe the type of info	ormation to be used or disclo	osed. Records	from the time	period:		_ to	
Information requested:	☐ All records (or specify) ☐ Allergy Records	☐ Clinic visit note☐Radiology Repo	s 🔲 Lab re	eports []Consultations	☐ Immur	nization records
5) In compliance with WI S	tatutes, the following inform	ation will not be rel	eased unless	box is cl	necked:		
☐ Mental health	☐ Alcohol &/or Dr	rug abuse	□ Developr	mental dis	ability	☐ HIV te	st results.
Patient Rights I understand that I if request. I understand that a longer be protected. I understand Prairi provision that I auth. I understand that I revocation in writing response to this auth. with the right to con. I understand that Fell I have questions of the same response to the same respon	Paper DVD Other	by the information usition, which I am not carries with it the part treatment, payment tected health informationization at any the restand that the revocation will incumstances when the patient rights list	ed or disclosed required to do otential for an out, enrollment ation. ime. I unders ocation will not apply to many health informed, I can contains	d in the au o, I will re unauthor in a heal tand that apply to y insuran mation ma	thorization. ceive a copy of the sized redisclosure the plan, or eligible if I revoke this authorized the company when the co	his signed and the indicate in the law phout my co	authorization uponformation may nefits based on the I must provide they been released in rovides my insurents.
	copies you request for purpose					us will be p	Tovided free of
8			9				
Signature of patient or repre-	sentative		Date signed				
If signed by person other than	n patient, state reason and aut	hority to do so. Pation	ent is	or 🗌 li	ncompetent/Incap	acitated	Deceased
	Guardian				_		
Rev (10/2012)	Pagainad on	h	Droops	od on		h	