Name:
DOB:
Chart:
Age:
Date:

Orthopaedic Associates of Wausau, S.C.
3200 Westhill Drive Suite 201
Wausau, WI 54401-4707
(Telephone 715-847-2382 or 877-260-6755 Fax 715-847-2381)

Patient Request for Release of Medical Information To Orthopaedic Associates of Wausau, SC

(Please complete in full)

1. Patient Name: _____
(Last, First, MI)

Date of Birth _____ Social Security Number: _____

2. **Records Release From:**

_____
(Name of Doctor/Clinic/Program)

_____
(Street Address)

_____
(City) (State) (ZIP)

3. **Records Released to:**
Orthopaedic Associates of Wausau, SC
3200 Westhill Dr. Suite 201
Wausau, WI 54401-4707

4. Date of Service: _____

5. Type of Information to be released: *(Check all that apply)*

☐ Medical History ☐ X-ray (Films ☐ Doctor's Notes
☐ Surgical Reports ☐ X-ray (Reports) ☐ Lab Results ☐ All

Any other specific information to be released. (Please give a meaningful description or explanation)

_____
_____

6. Purpose of release:
☐ Continuing Care ☐ Insurance Application / Claim ☐ Worker's Comp
☐ Personal / Other _____

I authorize (clinic or provider name) _____ to release information as described above. I understand that this authorization is voluntary. I may revoke this authorization by providing my revocation in writing.

I understand that (clinic or provider name) _____ may charge a fee for copies of these records. **I also understand that generating facility has the right to impose a reasonable, cost-based fee for copying, postage and preparation of records associated with fulfilling this request and I will be responsible for any associated fees.**

This authorization will be effective for medical records generated by (clinic or provider name) _____ to the date of signature and created or prepared during the effective period of the release. By signing this Authorization for Release, I am authorizing the release of all requested records to Orthopaedic Associates of Wausau, S.C.

This authorization expires on ____/____/____ (MM/DD/YY). If I do not indicate a date, this will expire one year from the date of my signature below.

_____ Date: _____
(Signature of Patient)

_____ Date: _____
And when applicable signature of:

☐ Parent of Legal Guardian
☐ Next of Kin of Deceased
☐ Power of Attorney

BC11