

Name:  
DOB:  
Chart:  
Age:  
Date:



### Patient Request for Authorization for Release of Medical Information

Not to be used for Orthopaedic Associates of Wausau, SC use or disclosure for its own purposes (please complete in full)

- Patient Name: \_\_\_\_\_  
(Last, First, MI)  
Date of Birth \_\_\_\_\_ Social Security Number: \_\_\_\_\_
- Records Release From: \_\_\_\_\_  
(Name of Doctor/Clinic/Program)  
\_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) (State) (ZIP)
- Records Released to: \_\_\_\_\_  
(Name of Clinic or Class of Persons)  
\_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) (State) (ZIP)
- Date of Service: \_\_\_\_\_
- Type of Information to be released: *(Check all that apply)*  
 Medical History       X-ray (Films)       Doctor's Notes       ALL  
 Surgical Reports       X-ray (Reports)       Lab Results  
Any other specific information to be released, please give a meaningful description or explanation:  
\_\_\_\_\_  
\_\_\_\_\_
- Purpose of release:  
 Continuing Care       Insurance Application / Claim       Worker's Comp  
 Personal / Other \_\_\_\_\_
- Special Instructions:  
 Mail       Pt. will pick up       For appt. on \_\_\_\_\_

**(We will not fax records unless it is an emergency and have verification of the fax number.)**

I authorize Orthopaedic Associates of Wausau, SC to release information as described above. I understand that this authorization is voluntary. I may revoke this authorization by providing my revocation in writing using the *Orthopaedic Associates of Wausau, SC Revocation of Authorization* form so long as Orthopaedic Associates of Wausau, SC has not yet relied upon and/or acted upon my authorization. I understand that I do not have the right to revoke this authorization if it was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim under the policy. I understand that information used or disclosed as a result of this may no longer be protected by federal privacy laws and may be further used or re-disclosed by persons or organizations receiving it.

I understand that if I agree, Orthopaedic Associates of Wausau, SC may choose to provide a summary or explanation of the requested protected health information. I also understand that Orthopaedic Associates of Wausau, SC may charge a fee for this summary/explanation. I also understand that **Orthopaedic Associates of Wausau, SC has the right to impose a reasonable, cost-based fee for copying, postage and preparation of records associated with fulfilling this request.**

This authorization will be effective for medical records generated by Orthopaedic Associates of Wausau, SC 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 Orthopaedic Associates of Wausau, SC records applicable to this request that are in my medical record file.

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.

\_\_\_\_\_  
(Signature of Patient)

Date: \_\_\_\_\_

And when applicable signature of:

Date: \_\_\_\_\_

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