



AUTHORIZATION TO RELEASE AND/OR INSPECT HEALTH INFORMATION

Patient:

Patient Name/Previous Names

Date of Birth/Medical Record Number

Street Address (include apartment number)

City, State, Zip Code

Authorizes: (Information to be released from)

Information, as described below, to be released to:

Surgical Associates of Neenah, S.C.

Name of Person or Entity Receiving Information

Name of Health Care Provider

100 Theda Clark Medical Plaza, Suite 400
Street Address

Street Address

Neenah, Wisconsin 54956
City/State/ZIP

City/State/ZIP

Information to be released includes:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consultations | <input type="checkbox"/> Provider's Orders and Progress Notes: | <input type="checkbox"/> Office Notes: |
| <input type="checkbox"/> Billing | <input type="checkbox"/> Operative Reports | Dates/Type: _____ | Dates of Visits: _____ |
| <input type="checkbox"/> Lab Reports | | | |

Reason for Disclosure:

- | | | | |
|--|--|-----------------------------------|--|
| <input type="checkbox"/> Changing providers/moving | <input type="checkbox"/> Legal | <input type="checkbox"/> FMLA | <input type="checkbox"/> Disability determination |
| <input type="checkbox"/> Consultation/further medical care | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Personal | <input type="checkbox"/> Payment/Insurance/Billing |
| <input type="checkbox"/> Other: _____ | | | |

I understand that if the persons(s) and/or entity(ies) listed above are not health care providers, health plans, or health care clearinghouses, all of whom must follow federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be used or re-disclosed without obtaining my authorization.

Your Rights With Respect to this Authorization

Right to Inspect or Copy the Health Information to be Used or Disclosed-I understand that I have the right to inspect or copy the health information by contacting Surgical Associates of Neenah, S.C. **Right to Receive Copy of this Authorization**-I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of this form. **Right to Refuse to Sign this Authorization**-I understand that I am under no obligation to sign this form and that the person(s) and/or entity(ies) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw this Authorization**-I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Surgical Associates of Neenah, S.C. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____ or for one (1) year from the date signed. I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient/Legal Representative: _____

Date: _____ (If signed by other than the patient, state relationship and authority to sign for the patient, i.e., minor, incompetent, deceased): _____

Request filled by: _____ (Employee) Date: _____ Records Released: _____