PAIN CLINIC
of NORTHWESTERN WISCONSIN

Stephen M. Endres MD DABPM
Mark R. Schlimgen MD DABPM

Phone: 715-552-5346
Toll Free: (888) 235-7246

1221 Whipple Street
P O Box 1185
Eau Claire, WI 54703

Authorization for Release of Medical Information

Patient Name _____ Date of Birth _____

Street Address _____ City / State / ZIP _____

Authorize release of records from:

Pain Clinic of Northwestern Wisconsin
P.O. Box 1185
Eau Claire WI 54702-1185

Records released to: _____
Name of individual / agency / organization

_____
Street Address

_____
City / State / ZIP

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

___ Medical history, exams, reports
___ X-ray reports
___ Consultations
___ Laboratory Reports
___ Progress notes
___ Prescriptions
___ Mental health records

Dates of treatment: All: ___ *-or-* Specific dates: _____

Purpose or need for release: _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Your Rights Regarding This Authorization:

Receive a Copy of Authorization – I understand that if I agree to sign this authorization, I will receive a copy of this authorization.

Refusal to Sign Authorization – I understand that I am under no obligation to sign this form and that the Pain Clinic of Northwestern Wisconsin may not condition treatment on my decision to sign this authorization.

Withdraw Authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the Pain Clinic of Northwestern Wisconsin. I am aware that my withdrawal will not be effective until received by the Pain Clinic of Northwestern Wisconsin and will not be effective regarding the uses and/or disclosures of my health information that Pain Clinic of Northwestern Wisconsin has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Inspect or Copy the Information to be used or Disclosed – I understand that I have the right to inspect or copy the information used or disclosed by this authorization. I may contact the Pain Clinic of Northwestern Wisconsin's Privacy Officer regarding this.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact the Pain Clinic of Northwestern Wisconsin's Privacy Officer.

Expiration Date: This authorization will remain in effect until _____
(Indicate date or event)

I understand I may revoke this authorization at any time by providing my written revocation.

_____ _____ _____
Signature of Patient / Authorized Representative Date Time

_____
Relationship to Patient (if signed by person other than patient)

PLEASE COMPLETE BOTH SIDES OF THIS FORM