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1221 Whipple Street
Eau Claire, WI 54703

Authorization for Release of Medical Information

Patient Name ______________________ Date of Birth ______________

Street Address ______________________ City / State / ZIP ______________

Authorize release of records to:

Pain Clinic of Northwestern Wisconsin
1221 Whipple Street
Eau Claire WI 54703

Records released from: ______________________________
Name of individual / agency / organization

____
Street Address

____
City / State / ZIP

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

___ Medical history, exams, reports

___ Consultations

___ Progress notes

___ Mental health records

___ X-ray reports

___ Laboratory Reports

___ Prescriptions

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

Purpose or need for release: ______________________________

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)