Pain Clinic of Northwestern Wisconsin
Authorization to Release and Disclose Patient Information

Patient information	Name:	Date of Birth:
Your personal information	Address:	Phone:
	City:	State:
	Zip:	
Clinic/Health Care Provider		
	Name:	
Who has the information	Address:	Phone:
you want released?	City:	State:
	Zip:	Fax:
Receiving Party	Name:	Attention :
WHERE do you want the information	Address:	Phone:
sent?	City:	State:
	Zip:	Fax:
Information to be released:	Clinic office notes, procedures, medications, consultations	( )
What do you want sent or released?	lab reports, radiology reports (if applicable)	( )
(please check)	Other (specify)	( )
	Records for the following date(s) of service From________________________to ____________________________	( )
Purpose of release:	Continuing care ( )	Transfer of care ( )
Why is it needed?	*Insurance ( )	*Personal Use ( )
(please check)	*Social Security disability determination ( )	*Legal/Litigation ( )
* Fees may be charged in accordance with Wisconsin Statutes.		

This authorization lasts for one year from the date of your signature unless you enter an expiration date here:____________________.

This authorization may be cancelled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Pain Clinic of Northwestern WI will not restrict my treatment if I choose not to sign this authorization.

A photocopy/ fax of this authorization will be treated in the same way as an original.

The Pain Clinic of Northwestern WI cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release the Pain Clinic of Northwestern WI from any and all liability resulting from a redisclosure by the recipient.

Your signature indicates that you have read and understand this form, and authorizes the release of your information as described above.

Patient/Legal Guardian Signature		Date:

Pain Clinic of Northwestern WI
PO Box 1185
Eau Claire, WI 54702-1185

715-838-6340 medical records
715-838-6596 medical records fax

www.painclinic-nw.com