Watertown Family Practice Associates, S.C.
127 Hospital Drive • Watertown, WI 53098
Phone: 920-261-8500
Fax: 920-261-8828

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in full. See reverse side for important information)

1.

_____
Name of Patient

_____
Street Address

_____
City, State, Zip code

_____
Date of Birth

I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization by providing written notice to Watertown Family Practice Associates, S.C. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. AUTHORIZE:

_____
(Name of Physician/Health Care Facility/Other)

_____
(Street Address)

_____
(City, State, Zip code)

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:
(If Release is to Self, State Self)

_____
(Name of Physician/Health Care Facility/Other)

_____
(Street Address)

_____
(City, State, Zip code)

4. HEALTH INFORMATION TO BE RELEASED:

❑ All medical Records ❑ Immunization Records ❑ Lab Reports ❑ X-ray Reports ❑ X-ray films (specify) ❑ Billing Records (specify)

❑ Other (Describe)_____

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From:_____/_____/_____ (DD/MM/YYYY) To:_____/_____/_____

4a. Federal and state laws require special permission to release certain information. Please check if these records should be released:

❑ Mental Health ❑ Alcohol and/or drug abuse ❑ HIV/AIDS test results ❑ Developmental Disabilities

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

❑ Further Medical Care ❑ Patient's Request ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation

❑ Other: _____

6. EXPIRATION

This authorization will expire on _____/_____/_____ (DD/MM/YYYY). If I do not indicate a date, this will expire one (1) year from the date of my signature below. A photocopy of this authorization is as valid as the original.

7. SIGNATURE

I understand that this authorization is voluntary. I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this Authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.