Fox Valley Surgical Specialists™

Form Completion Request

Not answering every question on this form may delay us in getting your form completed. You must complete and sign the "Authorization for Disclosure of Health Information" at the bottom of this form for us to release your medical information.

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____

Your Provider's Name: _____ Date of Surgery: _____

Did you miss work? Yes: _____ No: _____ Not Applicable: _____

If yes, 1st Day missed: _____ Planned Return to Work Date: _____

Reason Missed Work: _____

How would you like to receive your form?

____ Mail

____ Call me when ready at this number: _____

____ Fax to this number: _____

When do you need your form? _____

For Office Use

Form Completed _____

Form Sent _____

Form Scanned _____

Please allow 5-7 business days for form completion.

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

(PHOTOCOPY OR FACSIMILE OF THE ORIGINAL AUTHORIZATION WILL BE CONSIDERED AS VALID AS THE ORIGINAL)

Information to be released from:

Fox Valley Surgical Specialists
2000 E. Milestone Dr.
Appleton, WI 54913

Information to be released to:

_____
_____
_____

Information to be released:

Information needed to fill out form(s)

Need for disclosure:

Form needs to be completed per patient request

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, who must follow the 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 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 I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information. **Right to receive copy of this authorization** – I understand I have a right to receive a copy of this authorization. **Right to refuse to sign this authorization** – I understand that I am under no obligation to sign this form and that the organization listed above who I am authorizing to 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 revoke this authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw this my authorization or to receive a copy of my withdrawal, I may contact medical records. 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 the authorization. **Expiration Date:** This authorization is good until the following date: _____ or for one 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 PATIENT/LEGAL REP: _____ DATE: _____

REASON FOR NON-PATIENT SIGNATURE: _____

(IF SIGNED BY OTHER THAN THE PATIENT, STATE RELATIONSHIP AND AUTHORITY TO SIGN FOR PATIENT SUCH AS POA/LEGAL GUARDIAN)