AUTHORIZATION TO RELEASE AND/OR INSPECT HEALTH INFORMATION

Please allow 5-7 business days for processing

Patient Name ______________________ Date of Birth ______________

Address ______________ City ______________ State ________ Zip Code ________

I hereby authorize:

Fox Valley Surgical Specialists
Name/Facility

2000 E. Milestone Drive
Street Address

Appleton, WI 54913
City/State/Zip Code

To disclose my protected health information, as described below, to:

____
Name/Facility

____
Street Address

____
City/State/Zip Code

INFORMATION TO BE RELEASED:

☐ Office Notes ☐ Discharge Summary ☐ History & Physical ☐ Consultation

☐ Pathology Reports ☐ Operative Reports ☐ X-Ray/Imaging ☐ Lab Reports ☐ Billing

REASON FOR DISCLOSURE:

☐ Changing Physicians ☐ Personal ☐ Legal ☐ Worker's Compensation ☐ Consultation/Continuing Care

☐ Disability ☐ Payment of Insurance Claim ☐ Application for Insurance ☐ FMLA Paperwork

☐ Other ______________________

- **A listing of the statutory exception to release HIV test results without consent is available.**

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without my authorization.

I understand that I have the right to:

- **Receive a copy of this authorization.**
- **Refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.**
- **Revoke this authorization, in writing, except to the extent that the disclosure has already been made to the person(s) and/or organization(s) listed above in reference to this authorization.**

This authorization will remain in effect until the following date ____________ or for one year from the date signed.

______________________ ______________________ ____________
Signature of Patient Print Name Date

(If signed by person other than patient, state relationship to patient)

Patient is: ☐ Minor ☐ Incapacitated ☐ Deceased

Legal Authority: ☐ Parent or Legal Guardian ☐ Next of Kin of Deceased