



# Authorization for Disclosure of Health Information

Orthopaedic Centers of Wisconsin  
(DBA Klasinski Clinic)

I hereby authorize:

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

## Klasinski Clinic

500 Vincent Street  
Stevens Point WI 54481  
Phone: 715-344-0701  
Fax: 715-344-4494

Name of Individual or Entity: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Information to be released:

- Disclosure of Health Information covering the period of care from:
  - (Specific Dates) \_\_\_\_\_ to \_\_\_\_\_ **OR**  All Dates
- Disclosure of Health Information in regard to treatment of (list specific body part(s)): \_\_\_\_\_
- Medical History/Examination Reports/Office Notes       Physical Therapy Notes
- Medication List       Surgical Reports
- Allergy List       Imaging Reports
- Laboratory Reports       Imaging Studies
- Other \_\_\_\_\_       All **OR**  Specific Body Part \_\_\_\_\_

State and federal law protect the following information. If this information applies to you and you would like this information to be disclosed, please check all that apply:

- HIV/AIDS Testing/Results
- Alcohol/Drug Abuse Records
- Mental Health/Psychotherapy Records

### Purpose for requesting information:

- Continuity of Care
- Insurance Request
- Workers Compensation Request
- Disability/FMLA
- Legal
- At the request of the patient
- Other (Please explain): \_\_\_\_\_

### By signing this authorization form:

- ❖ I have the right to receive a copy of this authorization.
- ❖ I have the right to 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
- ❖ I have the right to revoke this authorization, except to the extent that the person(s) and/or organization(s) listed above have made in reference to this authorization. Revocation must be made in writing and presented to the Medical Records Department at Klasinski Clinic. Revocation will not apply to information that has already been disclosed in response to this authorization.
- ❖ 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 requests for copies of medical records are subject to reproduction fees in accordance with the federal/state regulations.

This authorization will remain in effect until the following date(s): \_\_\_\_\_, or event: \_\_\_\_\_

(Note: If no effective date is indicated, the authorization will remain in effect for one year from date of signature)

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Patient or Legal Representative

Relationship to Patient

Date: \_\_\_\_\_

