SHEBOGYAN INTERNAL MEDICINE ASSOCIATES, S.C.
AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

(Individual/Patient/Client/Insured):

_____ _____(___)_____

Name of Individual/Previous Names | Birth Date | Phone

AUTHORIZES: **DISCLOSURE OF PROTECTED HEALTH INFORMATION TO**

_____ _____

Individual(s)/agency/organization making disclosure | Individual/agency/organization receiving information

_____ _____

Street Address | Street Address

_____ _____

City, State, Zip Code | City, State, Zip Code

INFORMATION TO BE RELEASED _____All diagnostic reports

_____Discharge Summary _____Lab _____X-ray Reports _____Psychosocial
_____History & Physical _____Operative _____X-ray Films _____Clinic Records
_____Emergency Room _____Pathology _____Cardiac Reports _____View Only
_____Therapy Records _____Transfer Care _____Other (Must Specify)_____

RECORD FROM TIME PERIOD OF_____TO_____

In compliance with WI Statutes, which require special permission to release otherwise privileged information, please release records pertaining to: (Check all that apply)

_____Alcoholism _____Development Disabilities
_____Drug Screen _____HIV test results, AIDS, or AIDS related diseases
_____Drug Abuse _____Mental Health
_____Other (Specify)_____

PURPOSE FOR NEED OF DISCLOSURE (Check applicable categories)

_____Continued Care _____Insurance/Billing _____Disability Determination _____Exchange of medical
_____Legal _____Personal _____Other_____ records/information

THIS AUTHORIZATION IS VALID FOR _____(not greater than one year)

I understand that I have a right to inspect and receive a copy of the material to be disclosed (subject to usual copying charges). I understand that written notification is necessary to revoke this authorization, except to the extent that information may have been released before the receipt of this notice. Your decision to sign this authorization will not affect your treatment. If this information is being disclosed to an individual or entity that is not a health care provider or a health plan, it may be subject to re-disclosure and no longer protected. A photocopy/facsimile of this form is as valid as the original.

_____ _____

Signature of Patient or ***** Patients Representative | Date

_____

Relationship to Patient

****Person authorized by the patient means the parent, guardian or legal custodian of a minor, the guardian of an individual adjudged incompetent, the personal representative or spouse of a deceased individual or any other person authorized in writing by the individual. If no spouse survives deceased individual, an adult member of the deceased individual's immediate family may qualify.

Copy or signed authorization made for requester: _____Yes By: _____