Authorization for Disclosure of Health Information

I hereby authorize:

Stevens Point Orthopedics
(formerly Klasinski Clinic)
500 Vincent Street
Stevens Point WI 54481
Phone: 715-344-0701
Fax: 715-344-4494

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

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
- Medication List
- Allergy List
- Laboratory Reports
- Other _____
- Physical Therapy Notes
- Surgical Reports
- Imaging Reports
- Imaging Studies

☐ 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
- Disability/FMLA
- Other (Please explain): _____
- Insurance Request
- Legal
- Workers Compensation Request
- At the request of the patient

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: _____

_____
Signature of Patient or Legal Representative

Street Address: _____

_____
Relationship to Patient

City/State/Zip Code: _____

Birth Date: _____ **Phone:** _____ **Date:** _____