COMPREHENSIVE ORTHOPAEDICS, S.C.

7401 104th Avenue Suite 110 Kenosha, WI 53142 Phone: 262-764-5595 Fax 262-764-9314

Email: *MedRecFax@CompOrtho.com*

Authorization to use/or Disclose Personal Health Information
A copy of this authorization will have the same force and effect as the original

Patients Name: _____

Date of Birth: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip:_____

I AUTHORIZE: Comprehensive Orthopaedics, S.C. To release my medical records, as CIRCLED:

Mail ***Fax*** ***Email*** ***Patient pick-up***

(Name & Address of Party you want **RECORDS RELEASED TO**)

Name: _____

Address: _____ City: _____ State: _____ Zip:_____

Fax:_____ Email: _____

*****Record Request may take up to 14 days to process*****

This authorization releases the requested medical information through the date indicated below.

INFORMATION TO BE RELEASED

All Medical Records:_____ (No other selection needs to be made if choosing all records)

Circle One **Specify part of body:_____ (check all that apply below)**

0 Clinical Chart Notes 0 Lab/Pathology Reports 0 Hospitalization 0 Billing Records

0 Diagnostic Reports Only (X-Ray, MRI/CT, EMG) 0 Images* 0 All Records 0 Other:_____

* images are provided via **email** link and are no longer burned to a disc

For the following items to be included in the use or disclosure, in compliance with Wisconsin Statues, please release Records pertaining to: (Check all that apply)

0 ***Mental Health*** 0 ***AIDS/HIV*** 0 ***Genetic Testing*** 0 ***Developmental Disabilities*** 0 ***Drugs/Alcohol Abuse***

PURPOSE OF THIS DISCLOSURE (check below):

0 Physician / Second Opinion 0 Moving Relocation 0 Attorney / Litigation 0 Insurance Request 0 Other: _____

1) I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer protected by this regulation. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
2) I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.
3) I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing.
4) I understand I may refuse to sign this authorization. Unless allowed by,law, my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, enrollment in a health plan, or eligibility for benefits.

Signature of Patient / Legal Representative **Date**

_____

Print Name Relationship

(Office Use Only)

Records/Images to be released: _____

*Released by:*_____ *Date:* _____