excellence in brain, spine and pain care

neurosciencegroup

AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

PATIENT:

Name of Patient/Previous Names

Birth Date/Medical Record Number

Street Address

City, State, Zip Code

AUTHORIZES:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

Information to be Released	**Date of Service**
( ) Info. Necessary for Continuing Care	
( ) History and Physical	
( ) Pathology Report	
( ) Labs	
( ) EKG/EMG/EEG	
( ) Immunizations	
( ) MRI	

	Date of Service
( ) Discharge Summary	
( ) Operative/Procedure Report	
( ) Consultations	
( ) X-rays	
( ) PT/SP/OT	
( ) Progress Notes	
( ) Other_____	

In compliance with Wisconsin Statutes which require special permission to release otherwise privileged information, please release records pertaining to:

( ) Alcohol Abuse or Test Results
( ) Drug Abuse or Test Results
( ) Mental Health
( ) Other _____

( ) Developmental Disabilities
( ) HIV Test Results, AIDS or AIDS-Related Disease
( ) Sexually Transmitted Disease

This disclosure is being made for the following purpose(s):

( ) Further Medical Care
( ) Relocation/Moving
( ) Insurance Change
( ) At the Request of an Individual
( ) Changing Physicians (explain) _____

( ) Work Comp
( ) Attorney/Court case
( ) Insurance
( ) Other (comments) _____

1305 W. American Drive, Neenah, WI 54956
(920) 725-9373 or (800) 201-1194

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Right to Inspect or Copy the Information to be Used or Disclosed
I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact Neuroscience Group's Privacy Officer.

Right to Receive a Copy of this Authorization
I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization.

Redisclosure of Information by Recipient
I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact Neuroscience Group's Privacy Officer at 1305 West American Drive, Neenah, WI 54956-2883. (920) 725-9373.

Prohibition of Conditions
Neuroscience Group may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

Right to Revoke Authorization
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to Neuroscience Group. I understand that **the revocation will not apply to information that has already been released in response to this authorization.** I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that if Neuroscience Group uses this authorization for marketing activities, I will be informed if they receive any direct or indirect remuneration related to the use or disclosure of my protected health information.

Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____
Please list date, event or condition

_____ _____
Signature of patient Date

_____ _____
Signature of personal representative, person authorized, by the patient or other legal authority Relationship/legal authority