Kaukauna Clinic, SC
"Your partners in Family Health Care"

Kaukauna Clinic, S.C.

305 East 12th Street
Kaukauna, WI 54130
Telephone
(920) 766-4656

Gregory A. Johnson, M.D.
Paul H. Russo, M.D.
Joseph C. Graunke, M.D.
Jennifer L. Schoening, M.D.
Timothy P. Culligan, M.D.
Kim Romenesko, R.N., APNP
Lori D. King, R.N., APNP
Jennifer L Baumgart, R.N., APNP

INFORMED CONSENT FOR DISCLOSURE OFPATIENT HEALTH CARE INFORMATION

1. _____ _____ _____
(Patient Name) (Birth Date) (Maiden Name)

_____ _____ _____
(Street Address) (City) (State) (Zip Code)

_____
(Telephone Number)

2. RELEASE RECORDS **FROM:**

_____

_____

_____

3. RELEASE RECORDS **TO:**

_____

_____

_____

4. INFORMATION TO BE RELEASED:

_____ All Clinic Records _____ Lab Reports _____ Obstetric Records
_____ X-Ray Reports _____ X-Ray Films _____Immunization Record
_____ Other (Please Specify) _____

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

_____ Mental Health _____ Development Disabilities
_____ Alcoholism _____ Drug Abuse
_____ HIV (AIDS) _____ Other _____

5. REASON FOR RELEASE:

_____ Changing Provider _____ Consultation _____ Out-of-town move
_____ Personal use _____ Other (Please Specify) _____

6. This authorization will remain in effect until this request is processed unless you specify the authorization to be effective for a longer period of time.

_____
(Specify Longer Time Period or "none")

7. I authorize release of my medical records in accordance with the specifications listed above. I understand written notification is necessary to cancel this request. I release Kaukauna Clinic, their employees and agents from all legal responsibility or liability that may arise from the act I have authorized. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act (HIPPA) and that the information would then no longer be protected by HIPPA and any related regulations. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment payment or enrollment).

8. SIGNATURE OF PATIENT: _____ DATE: _____
If signed by person other than patient, state relationship and authority to do so.
RELATIONSHIP OF PATIENT: _____ WITNESS: _____

KAUKAUNA CLINIC RESERVES THE RIGHT TO CHARGE FOR THE COPYING OF MEDICAL RECORDS.

Medical Records sent out/picked up on: _____ By: _____