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

Kaukauna Clinic, S.C.

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INFORMED CONSENT FOR DISCLOURE OF PATIENT HEALTH CARE INFORMATION

Patient name: _____ Birth Date: _____
Maiden name:_____
Address: _____
City: _____ State: _____ Zip: _____
Telephone number: _____
Release records **from**:

_____

_____

Release records **to**:

_____

_____

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 _____

REASON FOR RELEASE:

___ Changing Provider ___ Consultation ___ Out-of-town move ___ Personal Use
___ Other (Please specify) _____

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 Long Time Period or "none")

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 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).

SIGNATURE OF PATIENT: _____ DATE: _____

If signed by person other than patient, state relations 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: _____