KAUKAUNA CLINIC, S.C.

305 E. 12th Street Kaukauna, WI. 54130 Office: 920.766.4656 Fax: 920.766.4659

INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

_____ _____ _____

Print Full Name Date of Birth Maiden Name

Complete Address/ State / Zip Code

( ) _____-_____

Telephone with Area Code

RELEASE RECORDS FROM:

_____

_____

_____

SEND RECORDS TO:

_____

_____

_____

INFORMATION TO BE RELEASED: **Please circle**.

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: **Please circle**.

Mental Health Development Disabilities Alcoholism Drug Abuse

HIV Other: (Please specify):_____

Any request for records concerning any visits, procedures, or surgery done at any other facility other then Kaukauna Clinic have to be requested from that facility.

REASON FOR RELEASE: Please circle

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. Please specify longer 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 agent 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 (HIPAA) and that the information would then no longer be protected by HIPAA 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 relationship and authority to do so.

RELATIONSHIP TO PATIENT:_____**WITNESS**:_____

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

Medical Records sent out/picked up on date:_____

By:_____

1/19/2023