Kaukauna Clinic, S.C.
305 E. 12th St.
Kaukauna, WI 54130

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PATIENT AGREEMENT

I authorize Kaukauna Clinic, S.C. staff to call my primary contact number or the phone number of the person identified below in reference to any information that would assist in the practice of carrying out treatment, payment and/or health care operations. This may include, but is not limited to, reporting/discussion of lab tests, pathology results, x-ray/ultrasound results, insurance issues, etc. If I am not available, information may be given to the person (people) identified on this form.

This authorization DOES NOT allow for release of medical records that is otherwise protected by law.

Granting release of information to: ____

Granting release of information to: ____

Patient Legal Name: ____
Date of Birth: ___________________________________

Do you give Kaukauna Clinic, S.C. permission to leave voicemail messages?
Please Circle: YES NO

I, the patient/parent/guardian, certify that I have received and understand this agreement and have been offered/received a copy of the HIPAA Privacy Notice.

Signature of Legal Name: ____ Date___________

Printed Legal Name: ______________________________________

12/22/23