

Green Bay Orthopedics LTD

Authorization for Release of Patient-Identifiable Health Information

Patient Name: _____

Patient DOB: _____

I authorize the use or disclosure of the above-named individual's health information as described below. I understand that I have the right to refuse to sign this authorization.

The following organization is authorized to make the disclosure:

Green Bay Orthopedics LTD	Phone:	920-965-4718
720 S Van Buren Suite 101	Fax:	920-430-8122
Green Bay WI 54301		

The following individual or organization is authorized to receive the disclosure:

Address (street, city, state, zip code):

Please check the specific information you would like released:

_____ Medical History, Exam, Reports _____ Treatment or test results

_____ Operative Reports _____ X-rays

_____ Health care information related to mental health, alcohol or drug abuse or a developmental disability

_____ HIV Test results According to Wis. Stat. § 252.15, I have the right to request a list of releases made of my HIV test results without my consent.

Please list a specific date range you would like released: _____

Authorization will remain in effect until: _____

Purpose of the use or disclosure: _____

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 Green Bay Orthopedics LTD'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 Green Bay Orthopedics LTD’s Privacy Officer at 720 S Van Buren Suite 101, Green Bay WI 54301, 920-430-8120.

Prohibition of Conditions

Green Bay Orthopedics LTD 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 Green Bay Orthopedics LTD. 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 Green Bay Orthopedics LTD 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.

Signature of patient

Date

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