MILWAUKEE ORTHOPAEDIC GROUP, LTD

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

______________________	________________	________________
Name of Patient	Birth Date	Patient Record Number

______________________	______________________________________
Street Address	City, State, Zip Code

I Authorize:

MILWAUKEE ORTHOPAEDIC GROUP, LTD
1218 W. KILBOURN AVE SUITE 301
MILWAUKEE, WI 53233
PHONE: 414-276-6000
FAX: 414-765-0021

To Release Protected Health Information To:

____
Name of Health Care Provider/Plan/Other

____
Street Address

____
City, State, Zip Code

____
Fax Number

____
Email Address

Information To Be Released:______ All Medical Records

________Office Notes
________ Consultation Reports
________Surgical Reports
________ Prescription Records
________X-ray/Radiology/MRI Reports
________Laboratory/Pathology Reports
________ Other (specify)______________________________________

Purpose /Reason For Disclosure of Protected Health Information:

________Insurance Eligibility/Benefit Determination/Verification
________Further Medical Care
________Application for Insurance
________Legal
________Other (specify)__________________________
________Personal

I understand that if the person(s) and or organizations(s) named above are not health care providers, health plans of health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Expiration Date: This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed.

Your Rights Pertaining To This Authorization: I understand that if I sign this Authorization, which I am required to do, that I might receive a signed copy of this Authorization if I request it.
Right to refuse to sign this Authorization: I understand that I am under no obligation to sign this Authorization.
Right to revoke this Authorization: I understand written notification is necessary to revoke this Authorization. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I may contact Milwaukee Orthopaedic Group. I am aware that my revocation will not be effective as to uses and or disclosures of my health information that the person(s) and or organization (s) named above have already made in reliance of this signed Authorization.

I have reviewed this Authorization. I understand the information presented in this Authorization and by signing this Authorization, I am confirming my approval for release of my protected health information.

Signature of Patient/Legal Representative: **Date:**

____
If signed by other than the patient, please indicate relationship to patient and legal authority for signature