wisconsin fertility INSTITUTE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Please complete in full)

Patient Name _____ Daytime Phone # _____ Date of Birth _____

Address _____ City, State Zip _____

TO RELEASE MEDICAL INFORMATION TO:
Wisconsin Fertility Institute (WFI)
3146 Deming Way
Middleton, WI 53562

Phone: 608-824-0075
Fax: 608-829-0748

AUTHORIZES DISCLOSURE FROM:

_____
Name of Health Provider/Organization/Individual

_____
Street Address

_____
City, State Zip

PURPOSE OF THIS DISCLOSURE:
❒ Transition to New Physician/Continued Medical Care

INFORMATION TO BE DISCLOSED:
(Note: Please see Disclosures Requiring Special Consent for AIDS/HIV, Mental Health, Alcohol/Drug Use, and Developmental Disabilities.)

Date Range: _____ to _____

_____ *Initials* This authorization shall also extend to records of future treatment, after the date of signature as long as such treatment occurs while this authorization is still in effect.
(Please initial if you also wish to have future records not yet created to be included with this release)

❒ Office Visit Notes ❒ Ultrasound Reports ❒ Ultrasound Pictures
❒ Laboratory Reports:_____
❒ Specific information related to:_____

YOUR RIGHTS REGARDING THIS AUTHORIZATION
Right to inspect or receive a copy of the health information to be used or disclosed: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.
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 may request a signed copy of the form.
Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. I am aware that I have the right to revoke this authorization by providing written notice to the health care provider who has been given this authorization.
Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

EXPIRATION DATE: This authorization is effective for one (1) year from the date signed unless otherwise indicated. _____
Date (Optional)

_____ _____
Patient or Legal Representative Signature/Relationship Date of Signature

DISCLOSURES REQUIRING SPECIAL CONSENT:
My signature below specifically authorizes the release of health information relating to testing, diagnosis and treatment for:
❒ AIDS/HIV/STDs ❒ Mental Health Care ❒ Alcohol/Drug Use ❒ Developmental Disabilities

_____ _____
Patient or Legal Representative Signature/Relationship Date of Signature
(Photostatic copy shall be valid as original.)