**Northeast Wisconsin Foot & Ankle Associates**

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# Authorization for Disclosure of Health Information

1. I authorize Northeast Wisconsin Foot & Ankle Associates to disclose the following information from the health records of:

   Patient Name: _____ Date of Birth: _____

   Address: _____

   Telephone #: _____ Patient MR: _____

   Covering the period(s) of health care:

   From (date) _____ to (date)_____

2. Information to be disclosed:
   - ☐ Complete health record
   - ☐ Discharge Summary ☐ History and Physical Examination ☐ Progress Notes ☐ Laboratory Tests
   - ☐ Consultation Reports ☐ X-ray Reports ☐ X-ray Images * ☐ Photographs, videotapes, digital, or other images
   - ☐ Other _____

   *CD (Digital) - $3 Non-Refundable Fee Required

3. I understand that the information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information is to be disclosed to:
   Name: _____
   Address: _____

5. The purpose of this disclosure is for:
   - ☐ My personal records ☐ Sharing with other healthcare providers
   - ☐ Other: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Northeast Wisconsin Foot & Ankle Associates. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

7. Northeast Wisconsin Foot & Ankle Associates, its employees, officers, and doctors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent I have indicated and authorized.

_____ _____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____

_____ _____

Signature of witness Date

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Office Use Only: ☐ $25 ☐ $3 ☐ Cash ☐ Check ☐ Credit Card