ReforMedicine SC
Direct Pay Family Practice

Authorization to Release Health Care Information

Patient	Name: _______________________ Maiden /Prev Name: ____________ Birthdate: _____________________ Telephone #: ___________________
Health Information Released FROM	ReforMedicine, SC 3004 Golf Road, Suite 103 Eau Claire, WI 54701 715-514-2827
Health Information Disclosed TO	Name of Person/ Organization: __________________________ Attn/Dept: ____ Street Address: _______________________________________ City/State/Zip: ____
Health Information to be Released (Please circle)	Verbal Exchange (no copies) Review of Records (no copies) Hard Copies (charge per page) Relating to: (Illness/Injury Date) __________ <u>Doctor Dictation</u> / Office Notes / History and Physical / Consults <u>Diagnostics</u> / Echos / EKG/Tracings / Lab(s) / Pathology <u>Miscellaneous</u> / Immunizations / Medications / HIV Test Results / Worker Illness/Injury / Treatment Plan/Review Other (Please Specify):
Purpose for Disclosure (Please circle)	Personal Continuity of Care Disability
Delivery Method (Please circle)	Mail Picked up by Patient /Authorized Designee Other
Authorization / Revocation	This <u>authorization will terminate in one year</u> unless otherwised specified: _______This <u>authorization may be revoked</u> at any time by providing a written notice of revocation to ReforMedicine, SC, except to the extent that this office have already taken action in reliance on it. Information used or disclosed pursuit to this authorization <u>may be subject to re-disclosure by the reciepient</u> and may no longer be protected by the Federal Privacy Rules. I understand that <u>ReforMedicine will not condition treatment</u> on whether I sign this authorization. I also specific ally authorize the release of my medical information <u>created after the date of my signature.</u> Signature ____ Date: _________________________ Relationship to Patient (if not patient)___________________________ **Note:** An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacited or deceased. Legal documentation of the right of access by the signing indivdual may be required. A photocopy of this authorization is as valid as the original. The patient may receive a copy of the signed authorization upon request. The patient has a right to inspect and receive a copy of the material to be disclosed. I understand that there is a charge per page of .10 per page for hard copy records.