ReforMedicine SC
Direct Pay Family Practice

Innovative, Passionate, Authentic
Transcending the Standards to provide affordable, accessible, and exceptional primary care.

Authorization to Release Health Care Information

Patient	Name: _____ Maiden /Previous Name: _____ Birthdate: _____ Telephone #: _____
Health Information Released TO / FROM	ReforMedicine, SC Direct Pay Family Practice Phone: 715-514-2827 3004 Golf Road, Suite 100 Fax: 888-606-1323 Eau Claire, WI 54701
Health Information Disclosed TO / FROM	Name of Person/ Organization: _____ Phone: _____ Attn/Dept: _____ Fax: _____ Street Address: _____ City/State/Zip: _____
Health Information to be Released	Check all that apply ☐ Provider Note(s) ☐ Operative Note(s) ☐ Radiology Report(s) ☐ Lab Result(s) ☐ Pathology Report(s) ☐ Other-Please Specify_____ **In Compliance with Wisconsin Statutes which requires special permission to release otherwise privileged information, please release records pertaining to:** *(Initial* to authorize release) _____Behavioral/Mental/Psychological Notes _____Substance Abuse and Treatment Records _____Developmental Disability Treatment Records _____HIV Lab test Results
Purpose for Disclosure (Please circle)	Personal Continuity of Care Disability
Authorization / Revocation	This authorization will terminate in one year unless otherwise specified: _____This authorization may be revoked 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 may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rules. I understand that ReforMedicine will not condition treatment on whether I sign this authorization. I also specifically authorize the release of my medical information created after the date of my signature. **Note:** An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual 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. Signature: _____ Date: _____ Relationship to Patient (if not patient):_____