

MORELAND FAMILY MEDICINE ASSOCIATES
717 WEST MORELAND BOULEVARD • WAUKESHA, WISCONSIN 53188
PHONE 262-542-9100 FAX 262-542-7366

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, ____/____/____/____
(Name of Patient) (Date of Birth) (Phone No.)

authorize _____
(Name of Organization making disclosure) (City) (State)

to release information to: _____
(Name of Person or Organization receiving information)

Address, City, and State of Person or Organization receiving information _____

1. The information shall be released by: _____ Mail _____ Pick-Up _____ Other

2. The type of information to be disclosed (check all that applies):

	Visit Date		Visit Date
_____ Office Notes	_____	_____ EKG Tracings	_____
_____ Pathology Report	_____	_____ X-Rays	_____
_____ Emergency Room	_____	_____ Lab Reports	_____
_____ Alcohol/Drug Report	_____	_____ Mental Health	_____

HIV Test Results _____
(Requires your signature here)

3. The purpose of the disclosure is (check one):

_____ Consultant/Specialist	_____ Payment of Claim/Benefits
_____ Transfer of medical Care	_____ Insurance Application
_____ Legal Investigation	_____ Personal Use
_____ Disability Determination/DVR	
_____ Other (Please specify) _____	

4. I understand that in accordance with State and Federal Confidentiality regulations the information disclosed may include reference to or treatment of alcohol/drug abuse, emotional illness, developmental disability, or psychiatric care. This release is executed in conformity with Wisconsin State Statutes 145.81-83, 51.30, 252.150. Further disclosure of this information without written consent is prohibited by law.

5. I understand that I may revoke this authorization by written notification at any time following this date, except for the information which may have been released prior to the revocation. Unless otherwise specified, this consent will expire one year from the signed date. This authorization will be effective for medical records generated to the date of signature.

Expiration date or condition/event to expire: _____

6. _____
Signature of person giving consent Date consent is signed

7. The signature is of the:

_____ Patient _____ Parent of Minor _____ Legal Guardian
_____ Patient's Executor or next of kin
_____ Person Authorized by Patient _____