2500 E. Capitol Drive, Suite 2600 ● Appleton, WI 54911 ● Phone: (920) 734-9600 ● Fax: (920) 734-4773

AUTHORIZATION OF RECORDS RELEASE

****GOVERNMENT ISSUED PHOTO ID REQUIRED TO MATCH SIGNATURE BEFORE RECORDS CAN BE RELEASED (If faxing this form and unable to pick up in person – you will need to attach a copy of a government issued photo ID now)**

Patient Name: ______________________________ Date of Birth: ____________________

Address: ______________________________ Phone: ____________________

I AUTHORIZE:	**RELEASE OF HEALTH RECORDS TO:**
______________________________	______________________________
Name of Health Care Provider/Plan/Other	Name of Health Care Provider/Plan/Other
______________________________	______________________________
Street Address Fox Valley Pulmonary Medicine SC 2500 E. Capitol Drive Suite 2600 Appleton, WI 54911	Street Address ______________________________
City, State, Zip Code	City, State, Zip Code

INFORMATION TO BE RELEASED:

☐ Office Notes
☐ Lab Reports
☐ Sleep Study
☐ Pulmonary Function Tests
☐ X-Ray Reports
☐ Hospital Notes
☐ Other ______________________________

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Alcohol Abuse or Test Results
☐ Drug Abuse or Test Results
☐ Mental Health
☐ Developmental Disabilities
☐ HIV Test Results, AIDS issues
☐ Sexually Transmitted Disease
☐ Other ______________________________

THIS DISCLOSURE IS BEING MADE FOR THE FOLLOWING PURPOSE(S):

☐ Medical Care ☐ Relocation ☐ Insurance ☐ Legal ☐ Other ______________________________

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

______________________________ ____________________

Signature **Date**

If signed by other than patient, state relationship and authority to do so.

☐ Parent ☐ Guardian ☐POA for Healthcare ☐ Spouse/Adult Family Member of Deceased Patient