



265 Griffin Street East . Amery, WI 54001 . (715) 268-8000
 Fax (715) 268-0381 www.amerymedicalcenter.org

Clear Lake Clinic
 357 Third Avenue
 Clear Lake, WI 54005
 (715) 263-3100
 Fax (715) 263-3102

Luck Medical Clinic
 137 First Avenue • P.O. Box 356
 Luck, WI 54853
 (715) 472-2177
 Fax (715) 472-8787

Turtle Lake Medical Clinic
 550 Martin Avenue
 Turtle Lake, WI 54889
 (715) 986-4101
 Fax (715) 986-4033

ARMC Rehab Services
 220 N Keller Avenue
 Amery, WI 54001
 (715) 268-1001
 Fax (715) 268-0111

Luck PT & Fitness
 2547 State Road 35, Suite 5
 Luck, WI 54853
 (715) 472-5225
 Fax (715) 472-5226

Authorization for Use and Disclosure of Patient Health Information

Name of Patient _____ Maiden or Previous Name _____ Birthdate _____
 Street Address _____ City, State, Zip Code _____
 Phone Number: (Home) _____ (Work) _____ (Other) _____

<p>I AUTHORIZE:</p> <p>_____ Name of Physician/Healthcare Facility</p> <p>_____ Street Address</p> <p>_____ City, State, Zip Code</p> <p>_____ Telephone # Fax #</p>	<p>TO RELEASE RECORDS TO:</p> <p>_____ Name of Physician/Healthcare Facility/or <u>Person</u></p> <p>_____ Street Address</p> <p>_____ City, State, Zip Code</p> <p>_____ Telephone # Fax #</p>
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Date(s) of Service Requested for Release: _____

Please check all that apply:

<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Lab Results/Pathology Reports	<input type="checkbox"/> Letters
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> OB Records
<input type="checkbox"/> ER Reports	<input type="checkbox"/> X-ray Reports	<input type="checkbox"/> Consultations
<input type="checkbox"/> Hospital Admissions	<input type="checkbox"/> X-ray Films/CD	<input type="checkbox"/> All (up to 3 years)
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Exchange of verbal / e-mail / written Communication (2 way)	<input type="checkbox"/> Records from other facilities
		<input type="checkbox"/> Other: _____

Reason for Disclosure: **I would like this information released for the following purpose:**

<input type="checkbox"/> Continued care by another provider	<input type="checkbox"/> Insurance purposes	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Attorney	<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> Other _____

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

Mental/Behavioral Health **Substance Abuse (Drug &/or Alcohol)** **HIV/AIDS related information**

Signature of patient or authorized person Date _____

I have read and understand the following:

- ❖ If I change my mind, I may write to the facility to revoke this authorization at any time. This will not apply to records that have already been released.
- ❖ This form expires one year after I sign it.
- ❖ Once the records are released, Amery Regional Medical Center cannot prevent them from being released to a third party.
- ❖ To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
- ❖ If I do not sign this form, I will still be treated, unless the treatment is part of a research project that requires this authorization.
- ❖ There may be fees associated with copying records.

*****If leaving our clinic—Reason:**

<input type="checkbox"/> Dissatisfaction	<input type="checkbox"/> Moving	<input type="checkbox"/> Insurance
<input type="checkbox"/> Convenience of Hours	<input type="checkbox"/> Convenience of Location	<input type="checkbox"/> Other _____

<p>_____ Signature of patient or authorized person (If authorized person is signing, please also print name)</p>	<p>_____ Authorized person's authority to sign (parent, guardian, power of attorney, etc.)</p>	<p>_____ Date</p>
<p>*photo ID required to pick up records/films</p>		
<p>REASON PATIENT IS UNABLE TO SIGN: <input type="checkbox"/> Minor <input type="checkbox"/> Deceased <input type="checkbox"/> Other: _____</p>		