Amery Regional MEDICAL CENTER
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) _____

I AUTHORIZE:

Name of Physician/Healthcare Facility _____

Street Address _____

City, State, Zip Code _____

Telephone # _____ Fax # _____

TO RELEASE RECORDS TO:

Name of Physician/Healthcare Facility/or Person _____

Street Address _____

City, State, Zip Code _____

Telephone # _____ Fax # _____

Date(s) of Service Requested for Release: _____

- ☐ Progress Notes
- ☐ Physical Therapy
- ☐ ER Reports
- ☐ Hospital Admissions
- ☐ Hospital Observations
- ☐ Lab Results/Pathology Reports
- ☐ Discharge Summaries
- ☐ X-ray Reports
- ☐ X-ray Films/CD
- ☐ Verbal/Email Communication
- ☐ Letters
- ☐ OB Records
- ☐ Operation Reports
- ☐ Consultations
- ☐ Other: _____

Reason for Disclosure:

I would like this information released for the following purpose:

- ☐ Continued care by another provider
- ☐ Attorney
- ☐ Insurance purposes
- ☐ Social Security Disability
- ☐ Personal Use
- ☐ 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.

*****If leaving our clinic—Reason:**

- ☐ Dissatisfaction
- ☐ Convenience of Hours
- ☐ Moving
- ☐ Convenience of Location
- ☐ Insurance
- ☐ Other _____

Signature of patient or authorized person _____ **Authorized person's authority to sign** _____ **Date** _____
(If authorized person is signing, please also print name) (parent, guardian, power of attorney, etc.)

***photo ID required to pick up records/films**

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other: _____

(Consent Man,GenForms)

Information Sent by: _____ Date: _____