SURGICAL ASSOCIATES
of Neenah, S.C.

AUTHORIZATION TO RELEASE AND/OR INSPECT HEALTH INFORMATION

Patient:

_____ _____
Patient Name/Previous Names | Date of Birth/Medical Record Number

_____ _____
Street Address (include apartment number) | City, State, Zip Code

Authorizes: (Information to be released from)

Surgical Associates of Neenah, S.C.
Name of Health Care Provider

100 Theda Clark Medical Plaza, Suite 400
Street Address

Neenah, Wisconsin 54956
City/State/ZIP

Information, as described below, to be released to:

_____
Name of Person or Entity Receiving Information

_____
Street Address

_____
City/State/ZIP

Information to be released includes:

- ☐ History and Physical
- ☐ Billing
- ☐ Lab Reports
- ☐ Consultations
- ☐ Operative Reports
- ☐ Provider's Orders and Progress Notes: Dates/Type:_____
- ☐ Office Notes: Dates of Visits:_____

Reason for Disclosure:

- ☐ Changing providers/moving
- ☐ Consultation/further medical care
- ☐ Other:_____
- ☐ Legal
- ☐ Worker's Compensation
- ☐ FMLA
- ☐ Personal
- ☐ Disability determination
- ☐ Payment/Insurance/Billing

I understand that if the persons(s) and/or entity(ies) listed above are not health care providers, health plans, or health care clearinghouses, all of whom must follow federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be used or re-disclosed without obtaining my authorization.

Your Rights With Respect to this Authorization

Right to Inspect or Copy the Health Information to be Used or Disclosed-I understand that I have the right to inspect or copy the health information by contacting Surgical Associates of Neenah, S.C. **Right to Receive Copy of this Authorization**-I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of this form. **Right to Refuse to Sign this Authorization**-I understand that I am under no obligation to sign this form and that the person(s) and/or entity(ies) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw this Authorization**-I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Surgical Associates of Neenah, S.C. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s)_____ or for one (1) year from the date signed. I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient/Legal Representative:_____

Date:_____(If signed by other than the patient, state relationship and authority to sign for the patient, i.e., minor, incompetent, deceased):_____

Request filled by:_____ (Employee) Date:_____Records Released:_____