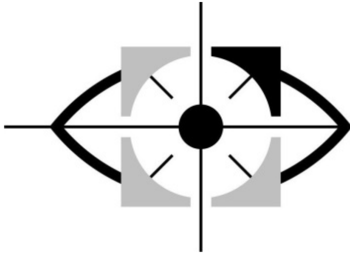

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name ______________________ **Date of Birth** ______________________

Street Address ______________________ **City, State, Zip Code** ______________________

I authorize: Northeast Wisconsin Vision Center to disclose my protected health information (as described below) From/To:

From	To
Northeast Wisconsin Vision Center **Name**	______________________ **Name**
1885 West Pointe Drive **Address**	______________________ **Address**
Oshkosh, WI 54902 **City, State, Zip Code**	______________________ **City, State, Zip Code**

Information to be released:

____**Medical History, examination, reports** ___**Prescriptions** _____**Hospital Reports**
____**Surgical Reports** ___**Consultations**

____**Other:**______________________

Purpose for Need of Disclosure: ___**Continuing Care** _____**Insurance**
____**Legal** ___**Personal**

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal standards and my health information might be re-disclosed without my authorization.

This Authorization will remain in effect until (one year from date signed) __________ **or event** __________

______________________ ______________________
Signature of Patient (or Legal Representative) **Date**

______________________ ______________________
Relationship to Patient **Date**

Authorized person means a parent, guardian or legal custodian of a minor child; the legal guardian of a patient judged incompetent; the spouse of a deceased patient.

Northeast Wisconsin Vision Center
1885 West Pointe Drive, Oshkosh, WI 54902
Phone: 920-232-6550 Fax: 920-232-6552