



Northeast Wisconsin Vision Center, Ltd.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name

Date of Birth

Street Address

City, State, Zip Code

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

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
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