

Willow Creek Women's Clinic
130 South Barstow Street, Suite 1B
Eau Claire, WI 54701

Authorization for Release of Medical Records

PATIENT INFORMATION (please print)

Name: _____ Date of birth _____

Previous names: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

RELEASE MY MEDICAL RECORD FROM:

Clinic name _____

Address: _____

PLEASE FORWARD MY MEDICAL RECORD TO:

Willow Creek Women's Clinic Phone: 715-832-9292
130 South Barstow, Suite 1B Fax: 715-832-4172
Eau Claire, WI 54701

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results, and diagnostic tests. To include Mental Health Records?
Please circle: Yes No

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient/Guardian _____ Date _____

PLEASE SEE OTHER SIDE

Your rights with respect to this authorization:

Right to receive a copy of this authorization – I understand that if I sign this authorization, I will be provided with a copy of this authorization upon request.

Right to refuse to sign this authorization – I understand that I am under no obligation to sign this form and that the covered entity may not condition treatment, payment, enrollment in a health plan, or eligibility for a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research related treatment, B) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating a PHI for disclosure to a third party.

Right to withdraw this authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to our Health Information Coordinator. I am aware that my withdrawal will not be effective until received by the previously mentioned clinic and will not be effective regarding the uses and/or disclosures of my health information that the clinic has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining health coverage, other law provides the insurer the right to contest a claim under policy or the policy itself.

Right to inspect or copy the health information to be used or disclosed – I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting our Health Information Coordinator.

HIV test results – I understand my HIV test results may be released without authorization to persons/organizations that have access under State Law.

Re-disclosure notice – I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal Privacy Standards.

Expiration date – This authorization is in effect for 6-months from the date of signature below unless otherwise stated. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient

Date: _____

Signature of personal representative or
person authorized by patient or legal authority

Relationship/Legal Authority