



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**PATIENT NAME:**

\_\_\_\_\_

Last First MI DOB

\_\_\_\_\_

Street Address City State Zip Code

\_\_\_\_\_

Phone Number Email Address

**AUTHORIZE RECORDS RELEASED TO:**

\_\_\_\_\_

Name

\_\_\_\_\_

Address

\_\_\_\_\_

City State Zip

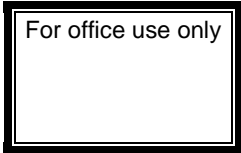
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- Office Notes
- Operative reports
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- X-ray Disks (\$11.28 per disk)
- Other: \_\_\_\_\_  
*(Please specify)*

**PURPOSE FOR THIS RELEASE:** \_\_\_\_\_

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**SIGNATURE OF PATIENT:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(If signed by person other than patient, state relationship): \_\_\_\_\_

***This authorization will expire one year from signature date.***  
*I understand that I may revoke this authorization at any time by providing my written revocation.*

This release is executed in conformity with Wis. Stats. §§146.81-83, 51.30, 252.15, and 102.13.