HAND to SHOULDER CENTER
of wisconsin®

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

RECORDS TO BE RELEASED FROM DATES OF SERVICE OF _____ TO _____

- ☐ Office Notes
- ☐ Operative reports
- ☐ Return to Work Slips
- ☐ Laboratory results (EMG, Radiology reports, etc.)
- ☐ Therapy Notes
- ☐ X-ray Disks ($11.07 per disk)
- ☐ Other: _____ *(Please specify)*

PURPOSE FOR THIS RELEASE: _____

RELEASE RECORDS FROM:

David A. Toivonen, M.D.
Jon J. Cherney, M.D.
Boyd C. Lumsden, M.D.
Scott P. Olvey, M.D.
Joseph P. Cullen, M.D.
Nathan L. Van Zeeland, M.D.
Matthew A. Butler, M.D.

For office use only

2323 North Casaloma Drive • Appleton, WI 54913
Phone: (920) 730-8833 • Toll-free: (888) 383-3039 • Fax: (920) 738-1974

IF RECORDS ARE 20 OR MORE PAGES, THERE WILL BE A CHARGE OF $0.35 PER PAGE PLUS POSTAGE. PREPAYMENT IS REQUIRED.

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.