



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME:

_____	_____	_____	_____
Last	First	MI	DOB
_____		_____	_____
Street Address		City	State
_____		_____	_____
Phone Number		Email Address	

AUTHORIZE RECORDS RELEASED TO:

Name		

Address		

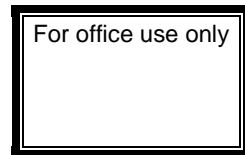
_____	_____	_____
City	State	Zip

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

- | | |
|--|---|
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Therapy Notes |
| <input type="checkbox"/> Operative reports | <input type="checkbox"/> X-ray Disks (\$11.07 per disk) |
| <input type="checkbox"/> Return to Work Slips | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Laboratory results (EMG, Radiology reports, etc.) | <i>(Please specify)</i> |

PURPOSE FOR THIS RELEASE: _____**RELEASE RECORDS FROM:**

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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.