Willow Creek Women's Clinic, 130 S. Barstow, Eau Claire, WI 54701 P: 715-832-9292 F:715-832-4172

Authorization to Release Health and/or Behavioral Health Care Information

(1) Patient	Name		Previous Name(s)	
	Birth Date		Phone Number	
(2) Info Release FROM	Address	City	State	Zip
(3) Info Disclosed TO	Individual/Facility/Organization:			
	Attn/Dept:		Contact Phone Number:	
	Address	City	State	Zip
	O **Mutual Exchanges** of information as noted in Section 4 between parties indicated in sections 2 and 3.			

(4) Health Info to be Released

O **COPIES** **Related to: (Clinical dept:/illness/Injury & Date):**_____.

O **Office Visits** O **Behavioral Health Information** **Date Range:**_____.

Provider Dictation	Diagnostics	Miscellaneous
O Office Notes	O Lab(s)	O Immunization
O ER Report	O Pathology Reports	O Medications
O History and Physical	O Radiology Reports	O Physical/Occupational Therapy
O Consults		O Pain Clinic
O Operative/ Proc Notes		O Resp. Therapy
O Discharge Summary		
O Behavioral Health		

O **Other** (please specify)_____.

O **VERBAL EXCHANGE** (no copies) O **REVIEW OF RECORD (no copies)**

(5) Purpose for Disclosure

O Personal O Continuity of Care O Work Comp
O Insurance O Disability O Legal O Other _____.

(6) Delivery Method

Information Needed By _____.
O Mail O Pick up by patient/authorized designee O Other_____.

(7) Authorization

This authorization with terminate in one year unless otherwise specified_____.
This authorization may be revoked at any time by providing a written notice of revocation to Willow Creek Women's Clinic releasing the information, except to the extent that the Providers checked above have already taken action in reliance on it. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rules.

☐ **By checking this box I authorize the release of medical information created after the date of my signature**

_____. _____.
Signature **Date**

_____. (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)
Relationship to Patient (if not parent)

Note: An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required. *A photocopy of this authorization is as valid as the original. The patient may receive a copy of the signed authorization upon request. The patient has a right to inspect and receive a copy of the material to be disclosed.