Northeast Wisconsin Retina Associates

Patient Name _____ Account Number _____

Authorization to Disclose Health Information

By completing this form, you allow Northeast Wisconsin Retina Associates to disclose health care information to the individuals you identify.

Person or entity that is to receive the information:

Name_____ Name_____

Phone_____ Phone_____

Relationship to You_____ Relationship to You_____

Information to be disclosed includes:

- ☐ All Information
- ☐ Appointment Information Only
- ☐ Billing/Payment Information Only
- ☐ All Health Information except_____

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Right to Revoke: I understand that I may revoke this authorization in writing at any time, except to the extent that the authorization was acted upon prior to revocation. Written notice may be sent to: Northeast Wisconsin Retina Associates, 442 N Westhill Blvd Suite A, Appleton, WI 54914.

Right to Review: I understand I have the right to inspect and receive a copy of the materials to be disclosed.

A copy of the authorization is valid as the original. I understand that I am entitled to a copy of this authorization after I sign it.

Patient Signature or Legally Authorized Representative_____Date_____

*NOTE: If you are signing as the member's Legally Authorized Representative, attach a copy of the appropriate documentation granting you the authority to do so. Examples would be a health care power of attorney, a court order, or guardianship papers.