Heart and Vascular Institute of Wisconsin™

Patient information:			
Name: ______________________	Date of Birth: ______________________		
Address: ______________________	City: __________	State: ____	Zip: __________
Primary Care Physician: ______________________			

Information to be released (Specify below for each individual):

I authorize the information described in this document to be released to the person(s) authorized below.

A. Information regarding appointment: diagnosis and procedures, cares planned, test results, statement of condition. Information for the purpose of assisting with billing: diagnosis, coverage, and payments. Information to support the planning of care services, i.e., transportation, appointments, home care, durable medical equipment.
B. Sensitive test results such as HIV, Pregnancy, sexually transmitted diseases.
C. Other: Patient is to specify: ______________________________________

Individuals Permitted (One or more please print):

Name: ______________________ Phone# ________________ Relationship:____________________

Choices: A B C

Name: ______________________ Phone# ________________ Relationship:____________________

Choices: A B C

Effective timeline for authorization:

This authorization shall remain in effect until:
□ My death
□ I authorize a change or revoke in writing

Your rights with respect to this authorization:

Right to Inspect or Copy the Health Information to be used or disclosed- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department. Right to Receive Copy of this Authorization - I understand that if I agree to sign this authorization, which I am not required to do so, I must be provided with a signed copy of the form. Right to refuse to sign this authorization- understand I am under no obligation to sign this form and the person(s)and or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to Withdraw this Authorization- I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department. I am aware my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s)listed above have already made in reference to this authorization.

Patient Signature: ______________________________ Date: _____/ _____/______

Person authorized by patient or other legal guardian: ____________________ Date: _____/_____/______