APPENDEX B
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

_____ _____
Name of the Patient Birth Date

_____ _____
Street Address City, State, Zip Code

I hereby authorize:

_____
Name of Individual or Entity

_____
Street Address

_____
City, State, Zip Code

To disclose my protected heath Information, as described below, to:

WOMENS HEALTH CARE OB-GYN,

1537 PARK PLACE, SUITE 200

GREEN BAY, WI 54304

Information to be released:

☐ Medical History, Examination Reports	☐ Treatment or Tests	☐ X – Ray Reports
☐ Laboratory Reports	☐ HIV Test Results*	☐ Mental Health
☐ Sexuality Transmitted Disease	☐ Surgical Reports	☐ Prescriptions
☐ Hospital Records Including Reports	☐ Developmental Disabilities	☐ Consultations
☐ Allergy Records	☐ Drug Abuse	☐ Alcoholism

☐ Other _____

*A listing of the statutory exceptions to release of HIV test results with out consent is available.

Purpose for Need of Disclosure

_____
_____
____ At the request of the individual

I understand that the health information disclosed as a result of this authorization may no longer to be protected by the federal privacy standards and my health information might be redisclosed without my authorization.

I understand that I have the right to:

- **Receive a Copy of This Authorization.**
- **Refuse to Sign This Authorization** and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke This Authorization,** except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s):_____, or event:_____

_____ _____
Signature of Patient (or Legal Representative) **Date**

_____ _____
Relationship to Patient **Date**

May take up to 3 weeks to process
(P) 920-498-8650 **(F)** 920-498-0945