APPENDEX B
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

____________________________	____________________________
Name of the Patient	Birth Date
____________________________	____________________________
Street Address	City, State, Zip Code

I hereby authorize:	**To disclose my protected heath Information, as described below, to:**
WOMENS HEALTH CARE OB-GYN,	____________________________ Name of Individual or Entity
1537 PARK PLACE, SUITE 200	____________________________ Street Address
GREEN BAY, WI 54304	____________________________ City, State, Zip Code

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

____

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____ 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