AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Name: ____________________________________ _____ ______________
MI DOB

Street Address: ____

City / State / Zip: ____

Records Released To:

Optima Health and Vitality Center
3321 A Golf Rd.
Eau Claire, WI 54701
Phone: 715-832-1953
Fax: 715-832-0225

Records Released From:

____
Name (Dr., Clinic, or Hospital)

____
Street Address

____
City State Zip

____
Phone Fax

Type of information to be disclosed. (Check all applicable categories.)

_____Progress Notes
_____Medication List
_____Immunization Records
_____Laboratory Reports
_____X-rays
_____Other ____________________________________
_____Operative Reports
_____Discharge Summaries
_____Consultations
_____Hospital Records – all reports
_____EKG Reports

This authorization includes records related to mental health, alcohol/drug abuse records, and HIV results unless excluded and signed by patient here: ____

The purpose of this disclosure is for: _____ Continued Medical Care
_____Personal Use
_____Legal Use
_____Insurance Use

This authorization will remain in effect until the records are received. I understand that written notification is necessary to cancel this request. This authorization may be revoked at any time, except to the extent action has been taken based on it.

____ ________________________

Signature of Patient **Date**

If signed by person other than patient, check necessity and authority to do so.
Patient is: _____ Minor _____Incompetent _____Deceased _____Other ___________________
Legal Authority: _____Legal Guardian _____Parent of Minor _____Next of kin of Deceased _____Other _______________