SURGICAL ASSOCIATES of Neenah, S.C.

SURGICAL ASSOCIATES OF NEENAH, S.C.
100 THEDA CLARK MEDICAL PLAZA
SUITE 100
NEENAH, WI 54956-5217
TELEPHONE: (920) 725-4527
FAX: (920) 729-2378

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____ DO HEREBY CONSENT TO AND
(NAME OF PATIENT)

AUTHORIZE _____ TO DISCLOSE TO
(NAME OF PHYSICIAN OR HEALTHCARE ORGANIZATION)

_____, INFORMATION FROM MY MEDICAL

RECORDS RELATING TO MY IDENTITY, DIAGNOSIS, PROGNOSIS OR TREATMENT COMPILED DURING MY MEDICAL TREATMENT(S)/HOSPITALIZATION FROM _____ TO _____, I UNDERSTAND THAT THE SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED INCLUDED:

_____

_____

_____

_____

I UNDERSTAND THAT THIS CONSENT MAY BE REVOKED EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN IN RELIANCE THEREON, AND THAT THIS AUTHORIZATION FOR DISCLOSURE WILL BE EFFECTIVE UNTIL:

_____
(TIME OR CONDITION)

_____

_____

_____ DATE: _____
Signature of Patient

— OR —

_____ DATE: _____
Person Authorizzed by Patient/And

_____ DATE: _____
Witness

_____
His/Her Relationship to Patient

NOTE TO RECIPIENT OF INFORMATION. THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM CONFIDENTIAL RECORDS, WHICH ARE PROTECTED BY LAW. UNLESS YOU HAVE FURTHER AUTHORIZATION, LAW MAY PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PATIENT OR LEGAL REPRESENTATIVE INVOLVED.

NOTE: PERSON AUTHORIZED BY THE PATIENT MEANS THE PARENT, GUARDIAN, OR LEGAL CUSTODIAN OF A MINOR PATIENT OR A PATIENT ADJUDGED INCOMPETENT, THE SPOUSE OR PERSONAL REPRESENTATIVE OF A DECEASED PATIENT; OR ANY OTHER AUTHORIZED IN WRITING BY THE PATIENT WHICH IS WITNESSED AND DATED.