INFORMED CONSENT FOR
RELEASE OF PATIENT HEALTH CARE INFORMATION

I, ____ ______/______/______ (______)______________
Name of Patient **DOB** **Telephone No.**

AUTHORIZE: BayCare Clinic Physician/Department(s) :____

TO RELEASE TO: ☐ ______________________________ ☐ **OBTAIN FROM:** ____________________________

☐ **MYSELF** ☐ **OTHER NAME:** ____

ADDRESS TO SEND: ____

____

INFORMATION FROM MY HEALTH CARE RECORD, TO INCLUDE:

- ☐ **Medical History, Examination, Reports**
- ☐ **Operative Reports**
- ☐ **Treatment or Test**
- ☐ **X-Ray Reports**
- ☐ **Hospital Records, including Reports**
- ☐ **Mental Health Records**
- ☐ **Genetic Tests**
- ☐ **Laboratory Reports**
- ☐ **Prescriptions**
- ☐ **Consultations**
- ☐ **HIV Test Results**
- ☐ **Copies of All Other Reports**
- ☐ **Emergency Department Reports**
- ☐ **Audiology Records/Reports**
- ☐ **Other** ________________________

FROM DATE: ________________________________ **TO DATE:** ____

FOR THE PURPOSE OF: (*INCLUDE ALL THAT APPLY)*

____ Personal Use ____Continuing Care ____Legal ____Employer Use ____Insurance ____ Other:________________________

I understand I can revoke this consent in writing, which will be effective only upon receipt by any BayCare Clinic Department. I understand the completion and signing of this form authorizes the release of information to the person mentioned above. This means that person may re-disclose my protected health information. This consent will remain in effect for a period of one year from the date of signature, unless otherwise revoked. A photocopy or facsimile of this authorization will have the same force and effect as the original.

I understand that I have a right to inspect the materials disclosed, upon written request to BayCare Clinic at no charge to me. I understand that I can receive a copy of the material to be disclosed as required under ss. HSS 92.05 and 92.06. I understand I may request a copy of this signed consent. I understand that information relating to my treatment may be released only upon my informed consent or as otherwise specified by 42 CFR, 45 CFR 164.508 and Wisconsin State Statutes 51.30, 146.025 and 146.81. I understand that my signature on this form is not required for me to receive treatment at this time.

____
SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE **DATE OF SIGNATURE**

____
(Name and Relationship of Legally Authorized Representative to Patient)

NOTE: Person authorized by the patient means the parent, guardian, or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the spouse or personal representative of a deceased patient, a person authorized in writing by the patient, a health care agent designated under Chapter 155, or a temporary guardian appointed by a court to consent to release of records. If no spouse survives, an adult member of the deceased's immediate family is authorized. **A copy of the appointment as personal representative, guardian or health care agent is required.**