



Beaver Dam
Women's Health, LTD

705 S. University Avenue, Suite 300
Beaver Dam, WI 53916
Phone (920)885-6090
Fax (920)885-6092

Ken Ostermann, MD
Elizabeth Nielsen, PA-C
Natalie Ross, APNP

Cindy Stippich, CNM
Brittany Froeming, CNM

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. PATIENT:

Name of Patient

Birthdate

Street Address

City, State, Zip

2. AUTHORIZE:

Name of Physician/Healthcare Facility

3. RELEASE RECORDS TO:

Name of Physician/Healthcare Facility

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

4. INFORMATION TO BE RELEASED:

- _____ Medical History, Examination, Reports
- _____ Treatment or Tests
- _____ Immunizations
- _____ X-ray Reports
- _____ Laboratory Reports
- _____ Summary of Chart

- _____ Surgical Reports
- _____ Hospital Records Including Reports
- _____ Allergy Records
- _____ Prescriptions
- _____ Consultations
- _____ Other (Specify): _____

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

- _____ Mental Health
- _____ Alcoholism
- _____ HIV (AIDS)
- _____ Other

- _____ Developmental Disabilities
- _____ Drug Abuse
- _____ Sexually Transmitted Diseases

(Specify): _____

FOR THE FOLLOWING DATE(S): _____

5. PURPOSE OF DISCLOSURE: (Check applicable categories)

Further Medical Care
 Application for Insurance
 Legal Investigation
 Personal
 Changing Physicians
 Other (Specify): _____

6. I understand that if the person(s) listed above are not healthcare providers, health plans or healthcare clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

7. Your Rights with Respect to This Authorization

- **Right to Inspect or Copy the Health Information to Be Used or Disclosed** – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Beaver Dam Women’s Health, Ltd.
- **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
- **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form and that the person(s) and/or organizations(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for healthcare benefits on my decision to sign this authorization
- **Right to Withdraw This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Beaver Dam Women’s Health, Ltd. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organizations(s) listed above have already made in reference to this authorization.

8. **Expiration Date:** This authorization is good until the following date(s) _____ or event(s) (specify event) _____ I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

9. **Signature of Patient:** _____ Date: _____
(If signed by person other than patient, state relationship and authority to do so)

Patient is: Minor Incompetent Disabled Deceased

Please Return To:

Beaver Dam Women’s Health, LTD
705 S. University Avenue, Suite 300
Beaver Dam, WI 53916
Phone (920)885-6090
Fax (920)885-6092