MedPoint
Family Care Center
2501 West Silver Spring Drive
Glendale, WI 53209
Tel: (414) 461-9250 Fax: (414) 461-3553

Release of Medical Records

AUTHORIZATION FOR USE / DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

_________________________ / _________________________
Patient Name — Previous Name (if different)

_________________________ / _________________________
Date of Birth — Social Security Number

- ❑ I AUTHORIZE THE FOLLOWING PERSON, INSTITUTION, OR FACILITY NAMED BELOW TO RELEASE INFORMATION FROM MY MEDICAL RECORDS TO THE ABOVE NAMED FACILITY.
- ❑ I AUTHORIZE MEDPOINT FAMILY CARE CENTER TO RELEASE MY MEDICAL RECORDS INFORMATION TO THE PERSON, INSTITUTION, OR FACILITY NAMED BELOW.

_________________________ / _________________________
Name — Phone Number

_________________________ / ____________ / ________ / ________
Street — City — State — Zip Code

INFORMATION TO BE RELEASED:

( ) Information Necessary For Continued Care
( ) History & Physical
( ) Labs
( ) EKG
( ) Ultrasound Report
( ) PFT Report
( ) Immunizations
( ) Consultations
( ) X-Rays
( ) Progress Notes
( ) Sleep Study Report
( ) Echo Report
( ) Stress Test Report
( ) Physical Therapy Notes

( ) Other:____

CONFIDENTIALITY NOTICE: PATIENT'S HEALTH INFORMATION IS CONFIDENTIAL AND RELEASED ACCORDING TO WISCONSIN STATUTES AND FEDERAL REGULATIONS. PATIENT'S HEALTH INFORMATION MAY NOT BE RE-DISCLOSED WITHOUT FURTHER WRITTEN AUTHORIZATION BY THE PATIENT

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_________________________ / ____________ / ____________
Patient / Guardian Signature — Date — Witness