West Madison
2702 Monroe St
Madison 53711
P: 608-231-3370
F: 608-231-1547

East Madison
3205 E Washington Ave
Madison 53704
P: 608-249-7657
F: 608-249-7728

Sun Prairie
1633 W Main St
Sun Prairie 53590
P: 608-837-7712
F: 608-825-6638

Oregon
978 Park St
Oregon 53575
P: 608-835-8635
F: 608-835-3772

700 Hwy 69 S
New Glarus 53574
P: 608-527-2715
F: 608-527-5796

Middleton
6704 University Ave
Middleton 53562
P: 608-836-4542
F: 608-836-9672

Fort Atkinson
825 Lexington Blvd
Fort Atkinson 53538
P: 920-563-4970
F: 920-563-8877

Verona
201 W Verona Ave
Verona 53593
P: 608-848-4227
F: 608-848-4229

Fitchburg
3070 Fish Hatchery Rd Ste 2
Fitchburg 53713
P: 608-271-7323
F: 608-268-9509

Whitewater
1173 W Main St Ste B
Whitewater 53190
P: 262-753-0017
F: 262-753-0022

Watertown
808 E Main St
Watertown 53094
P: 920-206-7959
F: 920-206-3272

Dean Spine Center
700 S Park St
Madison 53715
P: 608-260-3435
F: 608-260-3454

Cottage Grove
204 W Cottage Grove Rd
Cottage Grove 53527
P: 608-839-1172
F: 608-839-1174

Sauk City
707 Phillips Blvd
Sauk City WI 53583
P: 608-643-8643
F: 608-643-4902

Waunakee
249 S Century Ave
Waunakee WI 53597
P: 608-850-7243
F: 608-850-7245

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. _____/_____
(Name of Patient) (Date of Birth)

_____/_____
(Street Address) (City, State, Zip Code)

I authorize the use and/or release of my protected health information (PHI) as described below. I understand that this authorization is voluntary and is made to confirm my instructions. I also understand that the information used and/or released as a result of this authorization may no longer be protected by federal privacy laws and may be further used and/or released by persons or organizations receiving it without obtaining my authorization.

2. I AUTHORIZE: (from**)**

_____
(Name of Physician/Health Care Facility)

_____

3. TO RELEASE PHI TO:

_____
(Name of Physician/Health Care Facility/Other)

_____

4. PHI TO BE RELEASED:

Please describe the health information you would like released:

_____.

_____.

For the following dates: _____

Unless checked below, it is assumed I want the following records included in the release:

____ Mental Health *(excluding psychotherapy notes) ____ HIV (AIDS) ____ Drug Abuse
____ Developmental Disabilities ____ Alcoholism

** Please note that the "Authorization for Release of Psychotherapy Notes" must be completed for the release of psychotherapy notes.*

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

____ Transfer of Medical Care ____ Specialty Consultation ____ Legal Investigation
____ Application for Insurance ____ Vocational Rehab Evaluation ____ Personal
____ Disability Determination ____ Visual Inspection of Records ____ Care of Patient
____ Other: _____

6. EXPIRATION DATE: This authorization will expire on _____/_____/_____ . If I do not specify a date, this authorization will remain in effect until this request is processed.

7. SIGNATURE: I understand that by signing this form, I am confirming my authorization for the health care provider named in Section 2 to use and/or disclose the protected health information described above, to the persons and/or organizations named in Section 3. I understand written notification is necessary to cancel this request.

_____/_____
(Signature of Patient)* (Date)

** If this authorization is signed by a representative of the patient, please complete the following:*

Representative's Name:_____

Patient is: ____ Minor ____ Incompetent ____ Disabled ____Deceased
Legal Authority: ____ Parent of Minor ____ Legal Guardian ____ Power of Attorney ____Next of Kin