Wisconsin
Colon & Rectal Clinic

670 Cormier Road, Green Bay, WI 54304
Phone (920) 494-9685 Fax (920) 494-9687

INFORMED CONSENT FOR RELEASE OF PATIENT HEALTH CARE INFORMATION

I, _____ ___/___/___ _____-___-_____ (____) _____
Name of Patient Birthdate Social Security # Phone #

_____
Street City State Zip Code

authorize **Wisconsin Colon & Rectal Clinic** to release information to **or** obtain information from:

☐ Self **or** ☐ Name _____
Address _____
_____

Information from my Health Care Record related to my surgery/treatment dates (or approximate dates) of _____ and treatment, if any, for alcohol or drug abuse/dependence, developmental disabilities, mental illness, AIDS, or HIV test results.

Specific information to be released includes:

__ Face Sheet __ Op/Procedure __ Lab __ Discharge Instructions
__ H & P __ Anesthesia Report __ X-Ray __ Orders/Progress Notes
__ HIV Test Results __ Pathology Report __ Consult __ Entire Record (past 5 years)
__ Mental Health/Alcohol __ Other _____

This release is being made for the following purpose(s): *Check all that apply*

___ Insurance ___ Continuing Care ___ Legal ___ Employer Use ___ FMLA
___ Personal Use* ___ Other _____

* If for personal use, the first set of copies will be provided at no charge.

I understand I can revoke this consent in writing, which will be effective upon receipt by Wisconsin Colon & Rectal Clinic. I understand Wisconsin Colon & Rectal Clinic is not responsible for releasing information prior to receipt of the written revocation. 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 has the same force and effect as the original.

I understand that, once released by Wisconsin Colon & Rectal Clinic, my protected health information could be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. Wisconsin Colon & Rectal Clinic has informed me that it may not condition treatment on whether I sign this authorization and I acknowledge that I have signed this authorization voluntarily.

_____ _____
Signature of Patient Date of Signature

_____ _____ _____
Person Authorized by Patient Relationship to Patient Date of Signature

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 designated health care agent, 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.