Authorization to Release Medical Information

Waukesha Pediatric Associates, Ltd.
1111 Delafield Street, Suite #115
Waukesha, WI 53188
OR
888 Thackeray Trail, Suite #115
Oconomowoc, WI 53066
262-542-2536

Dr. Julia Ostendorf
Dr. Amy Attwell
Dr. Matthew Biebel
Dr. Meghan Kinateder
Dr. Sarah Hansen
Dr. Stephanie Whitt
Dr. Thomas DuBois

1) _____ 2) _____
(Patient name) (Patient's DOB)

3) _____ 4) _____
(Address) (Phone Number)

5)I authorize Waukesha Pediatric Association/Physician to release Medical Records to:

_____
(Facility Name and full return address)

6) Type of records we are requesting:
- ◊ Any and all types of records you have for this patient
- ◊ Office notes
- ◊ Immunization list
- ◊ Growth chart
- ◊ Labs
- ◊ Radiology Reports
- ◊ Other:_____

7) Records dated _____ and _____

8) In compliance with Wisconsin Statutes which require special permission to disclose otherwise privileged information, I'm authorizing that the following information also be disclosed. Check those that apply:
- ◊ Mental/Behavioral Health
- ◊ HIV/AIDS

9) Records will be (check one):
- ◊ Released my mail
- ◊ Picked up on site

10) Records will be used for:
- ◊ Continuing of care
- ◊ Personal use

11) Purpose for Disclosure:
- ◊ Continuing of care
- ◊ Transfer to New Provider
- ◊ Personal use
- ◊ Other:_____

I have the right to revoke this authorization in writing except to the extent that Waukesha Pediatric Association, LTD. has already taken action.

I understand that information disclosed may be re-disclosed and no longer protected by Federal regulations.

I understand that Waukesha Pediatrics may not condition the patient's healthcare on this authorization unless 1) the purpose of Waukesha Pediatrics evaluation and treatment is to obtain and disclose information to entities consistent to entities with the authorization or 2) the patient is involved in research-related treatment and the use or disclosure is for such research.

12) Patient's Signature_____13) Date_____

Authorized Representative_____ Date_____

Relationship of Authorized Representative_____