AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
GREEN BAY PLASTIC SURGICAL ASSOCIATES

PATIENT INFO: **PLEASE PRINT AND COMPLETE *IN FULL***

_____ _____ _____ _____ / _____ / _____
Last Name First Name Middle Initial Date of Birth

_____ _____ _____ _____ _____
Street Address Apt # City State Zip

_____ _____ _____
Home Phone # Work Phone # Ext

_____ _____
Doctor Chart #

RECORDS RELEASED FROM:

_____
Name

_____
Street Address

_____
City **State** **Zip**

AUTHORIZE RECORDS RELEASE TO:

Green Bay Plastic Surgical Associates

704 South Webster Avenue

Green Bay, WI 54301-3583

TYPE OF INFO TO BE RELEASED: (PLEASE CHECK ***ALL*** APPLICABLE CATEGORIES)

_____ ALL INFORMATION
_____ Medical History
_____ Examination & Reports
_____ Treatment or Tests
_____ Operative Reports
_____ Pictures
_____ Hospital Records/Reports
_____ Laboratoty Reports
_____ X-Ray Reports
_____ Prescriptions
_____ Emergency Department Reports
_____ Copies of all other Reports
_____ Other_____
_____
_____

Purpose / Reason for Release: _____

This Authorization is Effective Until the Following Date: _____ / _____ / _____
(Although this effective date may be a future date, we are only allowed by law to disclose information gathered up to and including your signature date. If your intention is to have us include future medical information, please ask for further instructions.)

I understand that I may revoke this authorization at any time by providing a written revocation.

_____ _____ / _____ / _____
Patient Signature *(If signed by person other than patient, state relationship below)* Date

Patient Is:

_____ Minor _____ Incompetent _____ Deceased

Signatory's Legal Authority:

_____ Parent _____ Legal Guardian _____ Deceased Next of Kin

***** This information has been released in accordance with state & federal laws – it contains information that is privileged, confidential, & exempt from disclosure under applicable state & federal law. Unless otherwise authorized by law, this information may not be re-disclosed without further written authorization of the patient. *****

- FOR GBPSA USE ONLY -

Verbal Notification _____ / _____ / _____ **Records Distributed** _____ / _____ / _____

Verified With: _____ **MAIL** **FAX** **PICK UP** **OTHER**