Mequon Wellness Center

Last Name: First: Date of Birth: / /

Address City State Zip

( ) ( )

Cell Phone Home Phone Email

I AUTHORIZE INFORMATION TO BE RELEASED FROM:	*INFORMATION WILL BE GIVEN TO/EXCHANGED WITH:*
Name/Facility	**Richard Lewis, MD** Name/Facility **Mequon Wellness Center**
Address City Zip	Address **11649 N. Port Washington Rd, Suite 114** City **Mequon, WI** Zip **53092**
( ) Phone Fax	Phone **(262) 235-3800** Fax **(262) 533-0252**

REASON INFORMATION IS NEEDED: CIRCLE ALL THAT APPLY (Copy fees may be charged)

Ongoing Medical Care Personal Use School Use Referral

Insurance Eligibility/Benefits Legal Investigation Other:_____

MEDICAL RECORD INFORMATION TO BE RELEASED: (SPECIFY CLINIC RECORDS)

Office Visits: Primary Care _____ Specialty (specify)_____ Procedures_____

From the following dates of service: From:_____To:_____

Only specified documents: CHECK ALL THAT APPLY

Immunization Records_____ Lab Reports_____ X-ray Reports_____

X-ray Films (specify)_____ Billing Records (specify)_____

Specific Information Related to: _____

I DO NOT WANT THE FOLLOWING INFORMATION RELEASED OR DISCUSSED: (as defined by applicable state and federal laws)

CIRCLE ALL THAT APPLY: Mental Health Sexually Transmitted Diseases HIV Test Results

Genetics Alcohol/Drug Treatment Other: _____

HOW INFORMATION WILL BE RELEASED:

Choose One: Verbal Disclosure / Paper / DVD/CD / MyChart /

Email: _____

IF PAPER OR ELECTRONIC, RELEASE BY:

US Mail

Fax (only to healthcare organizations): _____

EXPIRATION DATE:

This Authorization is valid until the following date/event: (not to exceed 3 years): _____
If no date is listed, this authorization is good for three (1) year from the date signed below.
This includes records that are created after the date this authorization is signed, up until the expiration date.

SIGNATURE

I understand this authorization is voluntary. I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature:_____Date_____

If this authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining mu authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization by providing written notice to Mequon Wellness Center Health Information. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.