The Heritage
2600 S Heritage Woods Drive
Appleton, WI 54915
920-738-3000

Patient Name: _____

Date of Birth: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____, give permission to The Heritage, to disclose my protected health information as described below with the person/people listed below. I understand that this authorization will remain in effect until I choose to revoke it.

Name	Phone Number	Relationship to Patient

Information to be released:

- ☐ Medical History
- ☐ Office Notes/Examination Reports
- ☐ Consultations
- ☐ Billing/Financial
- ☐ Verbal Exchange of Information Regarding Current Health
- ☐ Treatment/Tests
- ☐ Ultrasound Reports
- ☐ Hospital/Surgical Reports
- ☐ Laboratory Reports
- ☐ Sexually Transmitted Disease Results
- ☐ HIV Test Results (A listing of the statutory exceptions to release HIV test results without consent is available)
- ☐ Review EPIC Chart
- ☐ Other:_____ _____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without my authorization.

I understand that I have the right to:

- **Receive a Copy of This Authorization.**
- **Refuse to Sign This Authorization;** and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke This Authorization,** except to the extent that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s): _____,

or event: _____

_____ _____

Signature of Patient (or Legal Representative) **Date**