Stoiber HealthCare, S.C.

Authorization for Disclosure of Health Information
Phone: 715-424-4646 Fax: 715-424-3354

Patient Name: _____ DOB:_____/_____/_____
Please print clearly

I hereby authorize**: Stoiber HealthCare, S.C**. to disclose my protected health information, as indicated below **to:**

_____
Name of Individual or Entity

_____ _____
Street Address City, State, Zip Code

I hereby authorize**: (the named individual or entity),** to disclose my health information as indicated below **to:**
Stoiber HealthCare, S.C. 1210 Parkwood Dr. Wisconsin Rapids, WI 54494

_____
Name of Individual or Entity

_____ _____
Street address City, State, Zip Code

Information to be released:

☐ Medical history, examination reports
☐ Lab reports
☐ Treatment or tests
☐ X-rays
☐ X-ray reports
☐ Consultations
☐ Hospital records and reports
☐ Surgical/Operation reports
☐ Prescriptions
☐ MRI ☐ MRI Reports
☐ HIV Test Results (a listing of statutory exceptions to release of HIV test results without consent is available)
☐ Other_____

☐ Health care information related to mental health, alcohol or drug abuse or a developmental disability
☐ HIV Test results according to Wis. Stat {252.15, I have the right to request a list of releases made of my HIV test results without my consent.

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 redisclosed without my authorization. I also understand that there are costs associated with copying my health information and accept responsibility for payment. The standard Wisconsin record copying fee is .31 per page, plus handling, certification, and postage fees.

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 healthcare 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.

Purpose or need for the disclosure: Further treatment ☐ Other _____

- **This authorization will remain in effect for one year from date below unless otherwise indicated by the following date(s), event or condition:_____**

_____ Date_____

Signature of Patient (or Legal Representative-indicate relationship to patient)