BLOUNT ORTHOPAEDIC ASSOCIATES

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INFORMED CONSENT AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

(Complete in full. See reverse side for instructions.)

1. _____ _____ _____ _____
(Patient Name) (Birthdate) (Maiden Name) (Patient Phone)

Authorizes the use or disclosure of my Protected Health Information, as described below.

2. AUTHORIZE:

BLOUNT ORTHOPAEDIC ASSOCIATES, S.C.
525 W. RIVERWOODS PARKWAY, SUITE 100
GLENDALE, WI 53212

3. TO RELEASE RECORDS TO:

Name: _____

Address: _____

City/State/Zip: _____

❑ Mail ❑ Pickup Choose Location ❑ Fax #_____

4. PROTECTED HEALTH INFORMATION TO BE RELEASED, USED OR DISCLOSED

❑ All Clinic Records ❑ Other (Specify) _____
❑ X-Ray Films ❑ _____

In compliance with Wisconsin statutes which require special permission to release otherwise privileged information, please release records to pertaining to:

❑Mental Health ❑ Developmental Disabilities ❑ Alcoholism ❑Drug Abuse ❑ HIV (AIDS)
❑ Other _____

5. PURPOSE OF DISCLOSURE:

❑ Further Medical Care ❑ Payment of Ins. Claim ❑ Legal Investigation ❑ Application for Insurance
❑ Vocation Rehab. Eva. ❑ Personal ❑ Disability Determination ❑ At the Request of the Individual
❑ Other _____

6. This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period.

_____
(Specify additional time period or "None")

7. I authorize release of my medical records in accordance with the specifications listed above. I understand I have the right to revoke this authorization and acknowledge that Blount Orthopaedic Associates, S.C. will use or disclose my Protected Health Information I release upon this authorization.

8. Signature of Patient:_____ Date: _____

Name or other specific identification of the person(s) or class of person(s) who are authorized to make the requested use or disclosure of my Protected Health Information. (If signed by person other than patient, state relationship and authority to do so)

Patient is: ❑ Minor ❑ Incompetent ❑ Disabled ❑ Deceased

Legal Authority: ❑ Legal ❑ Legal Guardian ❑ Next of Kin of Deceased ❑ Personal Representative

By signing this authorization, I acknowledge that I have read and understand this authorization and I authorize the use and disclosure of my Protected Health Information in accordance with the terms of this authorization.

9. Signature of Witness: _____ Date: _____

BLOUNT ORTHOPAEDIC ASSOCIATES, S.C. RESERVES THE RIGHT TO CHARGE FOR THE COPYING OF MEDICAL RECORDS.

FOR OFFICE USE ONLY: Date Copied/Sent: _____ Completed by: _____

OVER →

ADDITIONAL INFORMATION REGARDING RELEASE OF PATIENT MEDICAL RECORDS

Blount Orthopaedic Associates, S.C. recognizes the patient's right to confidentiality of medical records as set form in Wisconsin Statutes. Therefore, the patient should be aware of the following guidelines when requesting medical records. The numbers listed below correspond to the numbered sections on the authorization form.

6. Wisconsin Statutes recognize the need for informed consent. The patient may request multiple releases of the information stated on the authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's signature. A new authorization is necessary for release if information on care provided after the date of the patient's signature, unless it is stated in the authorization to release "future records of a specific test, specified clinic appointment."

7. Generally, all patients 18 years of age and older must sign for release of their records. Read the following to determine exceptions for patients older or younger than 18 years.

    - All patients 18 years of age and over must sign for release of their own medical records unless the following conditions apply:

        a. The patient is incompetent.
        b. The patient is disabled and cannot sign the form.
        c. The patient is deceased. (The surviving spouse or legal representative must sign authorizations releasing records of deceased patient.)

    - Patients less than 18 years of age must sign for release of their medical records when:

        a. The patient is 14 years of age or older and the records involve treatment for mental illness, alcoholism, drug dependence and AIDS testing.
        b. The patient's records for release include abortion procedure.

    - All persons signing for release of records, instead of the patient, must state their relationship to the patient and have available proof of legal authority to release the records.

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient and legal representative involved.

Any request for records concerning any visits, procedures, or surgery done an any other facility other than ours may have to be requested from that facility.

Blount Orthopaedic Associates, S.C. reserves the right to charge for the copying of medical records.