# GREAT LAKES NEUROSURGICAL ASSOCIATES, LLC

## Authorization to Disclose Health Information

Patient Name _____________________________________ Date of Birth ___________________
Address ________________________________________________________________________
City ____________________________ State ______________ Zip _________________
Home phone number ______________________ Cell Phone number _________________

I authorize the use or disclosure of the above named patient's health information as described below:
From: Great Lakes Neurosurgical Associates To: _____________________________________
4600 W LOOMIS RD. #101 _____________________________________
GREENFIELD WI 53220 _____________________________________

INFORMATION TO BE DISCLOSED:

☐ Progress Notes ◻ Diagnostic Reports ◻ other (specify) __________________________

In compliance with WI Statutes, which requires special permission to release, please release medical records pertaining to: (check all that apply)

◻Mental Health ◻Developmental Disability ◻Alcohol and/or substance abuse ◻HIV test results

PURPOSE OF DISCLOSURE: (check all that apply)

◻ Further Medical Care ◻Second Opinion ◻Claims Resolution ◻Personal file
◻Other (specify) ______________________________

### YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

I have the right to ask for a copy of this authorization. I understand that I am under no obligation to sign this form and that Great Lakes Neurosurgical Associates may not condition treatment or payment on my decision to sign this authorization. I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the Privacy Officer at Great Lakes Neurosurgical Associates. I am aware that my withdrawal will not be effective until it is received by the Privacy Officer and will not be effective regarding the uses and/or disclosure of my health information that Great Lakes Neurosurgical Associates has made prior to receipt of my withdrawal statement. I understand that I have the right to inspect or copy the health information I have authorized to be disclosed by this authorization form. I understand my HIV test results may be released without authorization to persons/organizations that have access under State Law and a list of those persons/organizations is available upon request. I understand that information used or disclosed based on the authorization may be subject to re-disclosure and no longer protected by Federal privacy standards. This authorization is good for a period of one year or until the following date _________________.

PATIENT SIGNATURE _____________________________________ DATE ___________________
Or LEGAL REPRESENTATIVE________________________________ DATE ___________________
◻Parent of Minor ◻Legal Guardian ◻Spouse of deceased ◻Other __________________________________