Mary McDonald, M.D., S.C.
2700 West 9th Avenue, Suite 300
Oshkosh, WI 54904
920-223-0490

Authorization for Release of Patient-Identifiable Health Information

Patient Name: _____ Patient DOB: _____

I authorize the use or disclosure of the above-named individual's health information as described below. I understand that I have the right to refuse to sign this authorization.

The office of Dr. Mary McDonald is authorized to make the disclosure to the following individual(s) and/or organization(s):

Individual/Organization Name:

_____

Name Relationship Telephone number

_____

Name Relationship Telephone number

_____

Name Relationship Telephone number

Describe the type and amount of information to be used or disclosed as follows:

- ☐ Clinic records
- ☐ Radiology (x-ray) reports
- ☐ Pathology reports
- ☐ Appointment reminder
- ☐ Other: _____
- ☐ Laboratory reports
- ☐ Operative reports
- ☐ Billing related information

☐ **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.

Purpose of the use or disclosure:

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This authorization will be effective for medical records accumulated through the date of the expiration event unless otherwise specified.

Right to Inspect or Copy the Information to be Used or Disclosed
I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact Mary McDonald, M.D., S.C.'s Privacy Officer.

Right to Receive a Copy of this Authorization
I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization.

Redisclosure of Information by Recipient
I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact Mary McDonald, M.D., S.C.'s Privacy Officer at (920) 223-0490.

Prohibition of Conditions
Mary McDonald, M.D., S.C. may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

Right to Revoke Authorization
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to Mary McDonald, M.D., S.C. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that if Mary McDonald, M.D., S.C. uses this authorization for marketing activities, I will be informed if they receive any direct or indirect compensation related to the use or disclosure of my protected health information.

Unless otherwise specified, or revoked, this authorization will expire twelve (12) months from the date of my signature below.

_____ _____
Signature of patient Date

_____ _____
Signature of personal representative, person authorized by the patient, or other legal authority Relationship/legal authority