



AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

1. I HEREBY AUTHORIZE Primary Record Site:

Melius, Schurr & Cardwell
 2955 Triverton Pike Drive
 Madison, WI 53711
 608.227-7007 * 608.227.7027 [f]

2. TO RELEASE TO:

 (Name of Physician/Healthcare Facility)

 (Street Address)

 (City, State, Zip Code)

3. INFORMATION TO BE RELEASED:

_____ Time Period _____ to _____
 _____ Time Period _____ to _____
 _____ Time Period _____ to _____

4. IN COMPLIANCE WITH WISCONSIN STATUTES, which require special permission to release otherwise privileged information, please release records pertaining to:

Alcoholism Drug Abuse Mental Health HIV Test Results, Aids or Aids Disease
 Other _____

5. PURPOSE OR NEED FOR DISCLOSURE: (check applicable categories)

Insurance Change Move to New Community Transfer to New MD
 Disability Determination Other _____

I UNDERSTAND THAT THIS AUTHORIZATION SHALL BE VALID FOR ONE YEAR UNLESS OTHERWISE STATED BELOW OR REVOKED THROUGH WRITTEN NOTICE TO MEDICAL RECORDS.

6. PATIENT IDENTIFICATION

 (Name)

 (Maiden Name)

 (Street Address)

 (City, State Zip)

Birth date: ____ / ____ / ____

 (home phone) (cell phone)

7. SIGNATURE

 Signature of Patient or Legal Guardian Date

 Relationship to Patient

Patient is:
 Minor Incompetent Disabled Deceased

Legal Authority: Legal Guardian Next of Kin

Person authorized by the patient means the parent, guardian or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person authorized in writing by the patient. If no spouse survives deceased patient, an adult member of the deceased patient's immediate family may qualify. A court-appointed temporary guardian may also qualify.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.