Melius, Schurr & Cardwell
Physicians for Women

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

1. **I HEREBY AUTHORIZE** Primary Record Site:

_____
(Name of Physician/Healthcare Facility)

_____
(Street Address)

_____
(City, State, Zip Code)

2. **TO RELEASE TO**:

Melius, Schurr & Cardwell
2955 Triverton Pike Drive
Madison, Wisconsin 53711
(608) 227.7007 * (608) 227.7027 fax

3. **INFORMATION TO BE RELEASED**:

_____
_____
_____

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.