MILWAUKEE NEUROLOGICAL INSTITUTE, SC

Specializing in advanced intracranial and spinal neurosurgery

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient_____ Birth Date_____

Street Address_____

RELEASE OF PROTECTED HEALTH INFORMATION TO: P.O. BOX 5054, SOUTHFIELD, MI 48086-5054

RECORDS DEPOSITION SERVICE Street Address P. 248-357-3330 F. 248-357-3337

Information to be released:

	Date of Service		Date of Service
___Info. Necessary for Cont. Care	_____	___Discharge Summary	_____
___History and Physical	_____	___Operative/Procedure Reports	_____
___Pathology Report	_____	___Consultations	_____
___Labs	_____	___Xrays	_____
___EKG/EMG/EEG	_____	___PT/SP/OT	_____
___ER/UC	_____	___Progress Notes	_____
___Immunizations	_____	X Other	ENTIRE MEDICAL FILE

In compliance with Wisconsin Statutes which require special permission to release otherwise privledged information please release records pertaining to:

___Alcohol Abuse or test results
___Drug abuse or test results
___Mental Health
___Developmental Disabilities
___HIV test results, AIDS or AIDS-Related
___Other _____

This disclosure is being made for the following purpose(s):

___Further Medical Care
___Relocation/moving
___Insurance change
___At the request of the individual
___Changing Physician
___Work Comp
___Attorney/court case
___Insurance
X Other (comments) PRE-TRIAL DISCOVERY

Redisclosure Notice: I understand the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient, and/or no longer is protected by Federal Privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Services Dept. Right to Receive Copy of This Authorization – I understand that if I agree to sign this authorization, I will be provided with a copy of it. Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits based on my decision to sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorizing disclosure. Authorization is needed to release information to payer's for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services). Right to Revoke This Authorization - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal I may contact the Health Information Services Dept. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for one year from the signed date.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT LEGAL REP: _____ DATE: _____
(If signed by other than the patient, state relationship and authority to do so)

___Parent ___Guardian___POA for Health Care___Spouse/Adult Family Member of deceased patient

Spencer J. Black, MD : Dan S. Heffez, MD : Max C. Lee, MD

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