



Shoreview Pediatrics, S.C.

## Authorization for Release of Patient-Identifiable Health Information

Patient Name \_\_\_\_\_ Medical Record # \_\_\_\_\_  
Patient DOB \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I authorize the use or disclosure of the above-named individual's health information PHI to be released as follows:

\_\_\_\_ Medical Record \_\_\_\_ X-rays \_\_\_\_ Immunizations \_\_\_\_ Other \_\_\_\_ Growth Chart

Reason for request:

\_\_\_\_ Continuing Care \_\_\_\_ Personal \_\_\_\_ Insurance \_\_\_\_ Attorney \_\_\_\_ Other

Transfer records from:

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

Transfer records to:

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

Return signed medical release to:

You may use our secure email: [reception@shoreviewpediatrics.com](mailto:reception@shoreviewpediatrics.com)

Fax: 414-272-6261 Mail to: Shoreview Pediatrics 2524 E Webster Place, Suite 301  
Milwaukee, WI 53211 Contact our office 414-272-7009 with any questions.

Signature and consent other side.

**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 Shoreview Pediatrics' Privacy Officer.

**Right to Receive a Copy of the Authorization**

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

**HIV Test results**

According to Wisconsin Statute 252.15, I have the right to request a list of releases made of my HIV test results without my consent.

**Re-disclosure of Information by Recipient**

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact Shoreview Pediatrics, S.C. Privacy Officer.

**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 Shoreview Pediatrics. 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 Shoreview Pediatrics uses this authorization for marketing activities, I will be informed if they receive any direct or indirect remuneration related to the use or disclosure of my PHI.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_

**Prohibition of Conditions**

Shoreview Pediatrics 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 PHI

\_\_\_\_\_  
**Signature of patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of personal representative, person  
authorized by the patient, or legal authority**

\_\_\_\_\_  
**Date**