_____ _____

Patient name: Last First MI Date of birth

I hereby authorize:
(Name and address of releasing facility)

_____
_____
_____
_____

To release information to:
Ann Shippy MD
6836 Bee Cave Rd Suite 114
Austin, 78746
fax 512-328-0700
phone 512-732-9975

PURPOSE OF DISCLOSURE:

( )Continuing care
( )Payment of claim
( )School
( )Worker's compensation
( )Legal
( )For personal use
( )Other (specify):

_____
_____

INFORMATION TO BE RELEASED

	between the dates of:		between the dates of:
( )Progress notes/Provider notes	_____	Diagnostic test reports	_____
( )Lab reports/Pathology	_____	Discharge summary	_____
( )X-Ray reports	_____	H&P exam/Initial eval	_____
( )X-Ray films/MRI	_____	Consult	_____
( )Correspondence	_____	Counselor/Therapist summary	_____
( )Procedure reports	_____	Orders	_____

( )Other (specify content and dates): _____
_____

ACKNOWLEDGEMENT OF UNDERSTANDING:

-- I understand the expiration date of this authorization is one year.
-- understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
-- understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.
-- understand by authorizing this use or disclosure of information there will be no conditions placed on my health care or payment for my health care.
-- understand I will receive a copy of this form after I have signed it.
-- I understand that in compliance with MN Statue 144.33 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.

_____ _____ _____

Signature of patient, parent of minor, or personal representative Relationship Date

AUTHORIZATION for USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION