Wisconsin Institute of Urology

Form Completion Request

Patient Name_______________________________________ Date of Birth__________________________

Address ____

Your Providers Name (doctor or NP) _______________________

Type of form: (i.e. disability, FMLA, day care, insurance, etc.) _____________________________

Did you miss any work? Yes_____ No _____

- If so, what dates _______________________________________
- Reason missed work ____________________________________
- Job Description____
- Work Restrictions if any__________________________________

How would you like to receive your form?

______Mail

______Fax to this number ________________

______Call me when form is ready to pick up _____________

When do you need your form? ___________

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Photocopy or facsimile of the original authorization will be considered as valid as the original.

INFORMATION TO BE RELEASED FROM:

Wisconsin Institute of Urology

INFORMATION RELEASED TO:

____
Name of Receiver

____
Street Address

____
City/State/Zip Code

Info to be disclosed: Any Wisconsin Institute of Urology, S.C. written or verbal PHI needed to complete FMLA/Disability forms contained in our designated records set.

I understand that if the person(s) and/or organization listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

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 department. **Right to Receive Copy of this Authorization—**I understand that if I agree to sign this authorization, which I am not required to do so, I must be provided with a signed copy of the form. **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 on my decision to sign this authorization. **Right to Withdraw this Authorization—**I understand that 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 department. 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 date signed. I have had 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 OF PATIENT/LEGAL REPRESENTATATIVE: ____

DATE: __________________ (If signed by other than the patient, state relationship and authority in which to sign for the patient, i.e. deceased, minor, incompetent)

Request filled by: ____________ (Employee) Date: ________ Records Released: ____