AFFILIATED HEALTH OF WISCONSIN **HIPAA2**
PAIN REHABILITATION ASSOCIATES, PHYSICAL THERAPY
FIBROMYALGIA CENTERS OF WISCONSIN
RADIOLOGY & DENTAL IMAGING
AUTHORIZATION FOR RELEASE OF
PATIENT-IDENTIFIABLE HEALTH INFORMATION

Patient Name: _____ DOB: _____ Acct # :_____

I authorize Affiliated Health of the use or disclosure of the above-named individual's health information as described. I understand that I have the right to refuse to provide any authorized person(s).

Due to HIPAA regulations, enacted to safeguard the privacy of patient health information, Affiliated Health of WI is permitted to disclose your protected health information in the provision, coordination or management of your health care. Affiliated Health of WI is authorized to disclose your protected health information for treatment, payment or health care operations.

Additionally, please indicate below, if there is anyone in your household – including your spouse – to whom Affiliated Health of WI may speak to regarding past, present and future information related to appointments, treatment, prescription refills, test results and/or payment issues,

I give the following named person(s) authorization to take messages or speak with Affiliated Health of WI on my behalf regarding (please check):

□ **Appointments,** □ **Financial,** □ **Medical,** □ **Insurance,** □ **All**

Name of authorized Person: _____ Relationship: _____

Name of authorized Person: _____ Relationship: _____

Name of authorized Person: _____ Relationship: _____

□ Emergency contact listed on my registration form: _____

_____ Initial I authorize the use and disclosure of my name, photographic/video/x-ray images, and/or testimonial for marketing (social media and/or advertising) and research/educational purposes by the practice name listed above. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

I, _____ acknowledge and understand that this information will be kept in my medical record and that this consent will remain in effect until further notice is given in writing. It is my responsibility to notify Affiliated Health of WI should I wish to change any of the contacts listed above.

_____ _____ _____
Signature of patient or personal representative Relationship if not patient Date