GREEN BAY ONCOLOGY

RELENTLESS.

Authorization for Release of Protected Health Information

Patient Identification: (Please Print)

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip Code

Date of Birth: _____ Maiden/Other Name: _____

Telephone: _____

Release Information From:

❑ Green Bay Oncology, LTD
1726 Shawano Avenue
Green Bay, Wisconsin 54303
Phone: (920)-884-3138 Fax: (920)-593-8580
Attention: _____

❑ Other (Specify Facility & Address. Include Phone & Fax if Known.)

_____

_____

_____

Release Information To:

❑ Green Bay Oncology, LTD
1726 Shawano Avenue
Green Bay, Wisconsin 54303
Phone: (920)-884-3138 Fax: 920-593-8580
Attention: _____

❑ Other (Specify Facility & Address. Include Phone & Fax if Known.)

_____

_____

_____

Purpose of Release:

❑ Treatment/Continued Care
❑ Insurance
❑ Legal Purposes
❑ Personal
❑ Other (Please Specify) _____

Information To Be Released:

Approximate Service Date(s):	**Information Needed By:**
_____	_____

❑ History & Physical ❑ Operative ❑ Pathology
❑ Office Notes ❑ Billing ❑ Lab Results
❑ Consults ❑ Radiology
❑ Other (Please Specify) _____

1. I understand that this authorization shall be valid for one year unless otherwise specified or revoked by me through written notice to the Medical Records Department. If you want to limit or extend this authorization please indicate below.
2. Specify date and/or condition: _____
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy Regulations. However, other State or Federal Law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that a copy of this form can be provided upon request.

By signing below, I acknowledge that I have read and understand this authorization.

_____
Print Full Name

_____ _____
Signature of Patient or Personal Representative Date