

**AUTHORIZATION FOR  
RELEASE OF MEDICAL INFORMATION**  
(Please complete in full)

**1. Patient:**

\_\_\_\_\_  
Name (please print) \_\_\_\_\_ Date of Birth

\_\_\_\_\_  
Street Address, City, State, Zip

**2. Authorized Records Released From:**

\_\_\_\_\_  
Name of Physician or Clinic

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

**3.) Records released to:**

Blount Orthopaedic Clinic  
Name of person or institution authorized by patient

625 E. St. Paul Ave.  
Street Address

Milwaukee, WI 53202  
City, State, Zip

**4. Type of information to be released. Pertaining to:** \_\_\_\_\_

(Check all applicable categories)

- |   |   |
|---|---|
| <input type="checkbox"/> Medical history      | <input type="checkbox"/> Return to work slip(s) |
| <input type="checkbox"/> Laboratory report(s) | <input type="checkbox"/> Prescription(s)        |
| <input type="checkbox"/> Operation report(s)  | <input type="checkbox"/> Treatment or test(s)   |
| <input type="checkbox"/> Radiology report(s)  | <input type="checkbox"/> Radiology film(s)      |
| <input type="checkbox"/> Consultation(s)      |   |

**5. Purpose or need for release:**

- |  |   |
|--|---|
| <input type="checkbox"/> At the request of the Patient | <input type="checkbox"/> Second Opinion |
| <input type="checkbox"/> New Doctor (i.e.: moving)     | <input type="checkbox"/> Other          |

**6. Expiration date:** \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or legal representative \_\_\_\_\_ Date

\_\_\_\_\_  
If signed by person other than patient, state relationship to patient.

Patient is:  Minor  Incompetent  Deceased    Legal Authority:  Parent or Legal Guardian  Next of Kin of Deceased

**This release is executed in conformity with Wis. Statutes §§146.81-.83 & 51.30. and HIPAA.**