AUTHORIZATION FOR RELEASE/REQUEST OF HEALTH INFORMATION

I authorize **Ronald D. Wobig M.D., P.C. dba Beaver Sports Medicine** to use and/or disclose a copy of the health

information described: _____ regarding _____
(i.e. MRI, X-RAY, RECORDS,) (patient name)

to _____
(where records are to be sent or who can have access)

for the purpose of _____.

The health information to be used and disclosed includes the information specifically authorized below as well as all other information in my health records relevant to the above-described purpose.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

___By initialing here, I specifically consent to the disclosure of my HIV/AIDS information.
___By initialing here, I specifically consent to the disclosure of my mental health information.
___By initialing here, I specifically consent to the disclosure of my genetic testing information.
___By initialing here, I specifically consent to the disclosure of my drug/alcohol diagnosis, treatment, or referral information, which requires under federal law a description above of how much and what kind of information is to be disclosed.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Unless previously revoked, this Authorization expires _____.

_____ _____
(print patient's name) (date)

By: _____
(signature of patient)

If we, the health care provider, are requesting this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:

(1) *We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
(2) *You may inspect a copy of the protected health information to be used or disclosed;
(3) *You may refuse to sign this Authorization; and
(4) *We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent you signed this Authorization as a condition to insurance coverage. To revoke this authorization, please contact our Privacy Officer.

_____

Patient Representative & relation to patient Date:

_____

Description of Authority