



Indianhead Medical Center

113 Fourth Avenue West

PO Box 300

Shell Lake, WI 54871

715-468-7833

Shell Lake Clinic
113 Fourth Avenue West
P.O. Box 300
Shell Lake, WI 54871
715-468-2711

Siren Clinic
24670 State Road 35/7
Suite 100
Siren, WI 54872
715-349-2910

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION					
Last Name:		First Name:		Middle Initial:	
Date of Birth:		Phone Number:			
Mailing Address:			City:	State:	Zip Code:
RELEASED FROM			RELEASED TO		
Provider Name:			Provider Name:		
Facility Name:			Facility Name:		
Mailing Address:			Mailing Address:		
City:	State:	Zip Code:	City:	State:	Zip Code:
Phone Number:	Fax Number:		Phone Number:	Fax Number:	
MEDICAL INFORMATION REQUESTED					
<input type="checkbox"/> All health records in the last two (2) years unless otherwise specified (chart notes, labs, x-rays, tests, etc.)					
<input type="checkbox"/> All health records relating to the following condition(s): _____					
<input type="checkbox"/> All health records relating to the following date(s): _____					
<input type="checkbox"/> Other: _____					
All information regarding alcohol and/or drug abuse or behavioral health will be released unless you restrict by initialing:					
<input type="checkbox"/> Do not release alcohol and/or drug abuse information			<input type="checkbox"/> Do not release behavior health information		
REASON FOR REQUEST					
<input type="checkbox"/> Transfer of Care		<input type="checkbox"/> Continuing Care		<input type="checkbox"/> Personal	<input type="checkbox"/> Other
AUTHORIZATION					
<p>I understand that I may revoke this consent in writing at any time except to the extent action has been taken. I understand that this consent will expire one (1) year from today's date unless otherwise specified. I understand that in compliance with WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records if for personal use. I understand that the information disclosed may be subject to redisclosure by the person or entity receiving it and would then no longer be protected by federal privacy regulations. I understand that the provision of treatment, payment, enrollment, or eligibility for benefits will not be conditioned on the elements of the authorization provided or your request for copies of patient records, unless permitted under 45 CFR 164.508(c)(2)(ii)(A)-(B).</p>					
_____ Signature of Patient or Guardian			_____ Date Signed		
_____ Relationship (If not signed by Patient)					

Faxed

Mailed

Date Sent: _____