Vision Forward Association

912 N Hawley Rd
Milwaukee, WI 53213
(414) 615-0100

AUTHORIZATION FOR USE, DISCLOSURE OR RELEASE OF PROTECTED HEALTH INFORMATION
(Photocopy/ Facsimilie may be used as original)

NAME	*Last*	*First*	*MI*
DATE OF BIRTH		**AKA**	

UNDERSTANDINGS:

1. I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
2. I understand **Vision Forward** will not deny treatment, payment, enrollment or eligibility for benefits based upon whether I sign this authorization. I also understand that an authorization may be necessary in order to process any request I have made for a release of medical records or other medical information. I may inspect or copy any information used or disclosed under this authorization.
3. I understand that I may revoke this authorization in writing at any time by mailing or delivering a written revocation to the Privacy Officer. The revocation will be effective upon receipt by **Vision Forward**, except to the extent that action has already taken place.
4. I further understand that, this authorization will expire as follows:
   - Sixty (60) days from the date that I have signed this form. After the expiration date, this authorization will no longer be effective, and no further information will be furnished without additional authorization.
5. I understand that there may be a charge to cover actual costs incurred in preparing and delivering the information requested in this authorization, in accordance with State statutes and our policies. The fee is currently [Enter amount] per page. There is **no charge** for medical records if copies are sent to facilities for ongoing care or follow up treatment.

REQUEST: [Submit this completed form to the Privacy Officer located at 912 N. Hawley Rd Milwaukee, WI 53213 Fax: (414) 256-8748]

I hereby authorize **Vision Forward** to release / receive information from my medical record as indicated below:

Name: ____

Address: ____
Street City State Zip

Phone: (______)________________________ Fax: (______)________________________

DATES AND TYPES OF INFORMATION TO DISCLOSE:

❐ **From Date:** ________________________________

❐ **To Date:** ________________________________

Specific Information Requested:

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PURPOSE OF THE DISCLOSURE:

❐ **Change in Insurance or Physician**

❐ **Continuation of Care**

❐ **Referral**

❐ **Other** ____________________________

SIGNATURE:

DATE:

If signed by someone other than the patient:

PRINTED NAME: ____________________________

ADDRESS: ____________________________

CITY: ____________________ **STATE:** _____

ZIP: ____________ **PHONE:** ____________________

RELATIONSHIP: ❐ Client/Patient ❐ Parent ❐ Guardian ❐ Representative ❐ Conservator ❐ Other ____________

Distribution: Original – Releaser of Records Copy - Patient's Chart/Medical Record Copy - Patient / Client