Release of Records

Patient name: _____

_____

_____

_____

_____

(please indicate all patients' names requesting records released)

Mailing address for records:

Name: _____

Address: _____

City: _____

State, Zip: _____

By signing below, the patient or responsible party gives us permission to have his/her records sent to the indicated party above upon payment of duplication fees:

Signature: _____
(patient's authorization signature, legal guardian or parent if patient is under 18)

Date: _____

Access to patient records and radiographs is governed by Wisconsin State Statute section 146.83. "…any patient or other person may, upon submitting a statement of informed consent:" Subdivision 2 (b) states: "Receive a copy of the patient's health care records upon payment of fees…" Subdivision 2 (c) states: "Receive a copy of the health care provider's X-ray reports or have the X-rays referred to another health care provider of the patient's choice upon payment of fees…"