AUTHORIZATION FOR RELEASE OF HEALTH CARE RECORDS

RE: ______________________________

Date of Birth: ________________

Soc. Sec. No. ________________

I, _________________________, authorize _________________________ pursuant to Wis. Stat. § 146.82(1) and 42 C.F.R. §§ 2.31 and 2.32 to disclose the health care records designated below to any representative of Derzon & Menard, S.C. The purpose of the disclosure of the information and records is for legal representation and investigation.

All patient health care records regarding physical, mental or psychological conditions for which I received care, treatment, or examination, including all records, reports, and correspondence authored by or sent to my health care providers pertaining to my physical, mental or psychological health, treatment, diagnosis, prognosis, or etiology, including all treatment records covered by § 51.30, Wis. Stats. and federal law applicable to treatment for alcoholism or drug dependency, all records regarding HIV and AIDS tests regarding personal health information pursuant to Wis. Stat. § 252.15(2), and charges for same. All correspondence to and from other health care providers.

This authorization further authorizes any treating or examining physician or any person named in a disclosed health care record to discuss the record and the conditions in the record, and, if requested, to prepare reports, summaries, or opinions regarding my condition.

I understand that my personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following, but not limited to, experts and consultants, other parties in this matter and their insurers, other attorneys representing parties in this matter, and the tribunal, court, or board hearing this matter, mediators, arbitrators and any agents, employees or representatives of them.

I understand that I may revoke this authorization in writing at any time to Derzon & Menard, S.C., except that Derzon & Menard, S.C. may rely upon any personal health information received prior to revocation of this authorization.

I understand that I may inspect the disclosed records upon written request to Derzon & Menard, S.C.

I understand that any treatment, payment, enrollment or eligibility for benefits is not conditioned upon me signing this authorization.

This authorization is effective for one year. This authorization may be revoked before its expiration, except to the extent that the health care provider has already acted in reliance upon it, by written notice to the health care provider identified above. A photocopy of this authorization is valid.

______________________ ______________________________

Date Patient/Parent/Legal Guardian

ALAN L. DERZON ROBERT C. MENARD

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