

**NEW Surgical Associates**  
670 Cormier Road, Green Bay, WI 54304  
Phone (920) 494-9685 Fax (920) 494-9687

**INFORMED CONSENT FOR RELEASE OF PATIENT HEALTH CARE INFORMATION**

I, \_\_\_\_\_ / / \_\_\_\_\_ ( ) \_\_\_\_\_  
Name of Patient Birthdate SS # Phone #

\_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code

Authorize \_\_\_\_\_  
Specify Health Care Provider/Clinic/Individual

- To release information to: **or**  To obtain information from:  
 Self **or**  Name \_\_\_\_\_  
& Address \_\_\_\_\_  
\_\_\_\_\_

Information from my Health Care Record related to my surgery/treatment dates (or approximate dates) of \_\_\_\_\_ and treatment, if any, for alcohol or drug abuse/dependence, developmental disabilities, mental illness, AIDS, or HIV test results.

**Specific information to be released includes:**

- Face Sheet  Op/Procedure  Lab  Discharge Instructions  
 H & P  Anesthesia Report  X-Ray  Orders/Progress Notes  
 HIV Test Results  Pathology Report  Consult  Entire Record (past 5 years)  
 Mental Health/Alcohol  Other \_\_\_\_\_

**This release is being made for the following purpose(s):** *Check all that apply*

- Insurance  Continuing Care  Legal  Employer Use  
 Personal Use\*  Other \_\_\_\_\_

\* If for personal use, the first set of copies will be provided at no charge.

I understand I can revoke this consent in writing, which will be effective upon receipt by NEW Surgical Associates. I understand NEW Surgical Associates is not responsible for releasing information prior to receipt of the written revocation. This consent will remain in effect for a period of one year from the date of signature, unless otherwise revoked. A photocopy or facsimile of this authorization has the same force and effect as the original.

I understand that, once released by NEW Surgical Associates, my protected health information could be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws. NEW Surgical Associates has informed me that it may not condition treatment on whether I sign this authorization and I acknowledge that I have signed this authorization voluntarily.

\_\_\_\_\_  
Signature of Patient Date of Signature

\_\_\_\_\_  
Person Authorized by Patient Relationship to Patient Date of Signature

**Note:** Person authorized by the patient means the parent, guardian, or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the spouse or personal representative of a deceased patient, a person authorized in writing by the patient, a designated health care agent, or a temporary guardian appointed by a court to consent to release of records. If no spouse survives, an adult member of the deceased's immediate family is authorized. A copy of the appointment as personal representative, guardian or health care agent is required.

Patient Account # \_\_\_\_\_ Date Request Received \_\_\_\_\_