Sheboygan Pediatrics
FROM CRADLE TO COLLEGE

William L. Trager, M.D.
Julie A. Roehrborn, M.D.
Jenny K. Brault, M.D.
Amy J. Harms, M.D.
Alyssa Pfeifer-Rentmeester, PA-C

2920 Superior Avenue, Sheboygan, WI 53081, Phone (920) 458-3331**, Fax (920) 458-1387**

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(Circle)

_____*Male/Female*
Name of Patient

_____ | _____
Birth Date | **Phone Number**

_____
Street Address

_____
City, State, Zip

I hereby authorize:

_____
Name

_____
Street Address

_____
City, State, Zip

_____
Phone & Fax

To disclose my protected health information, As described below, to:

_____
Name of Individual or Family

_____
Street Address

_____
City, State, Zip

_____
Phone & Fax

Information to be released:

_____Medical History, Exam Reports
_____Hospital Records including Reports
_____Laboratory Reports
_____Consultations
_____Sexually Transmitted Disease
_____Other
_____Surgical Reports
_____X-ray Reports
_____Prescriptions
_____Mental Health
_____Drug Abuse
_____**All Records**
_____Treatment or Tests
_____Developmental Disabilities
_____HIV Test Results*
_____Allergy Records
_____Alcoholism

**A listing of the statutory exceptions to release HIV test results without consent is available.*

Purpose for Need of Disclosure - _____

_____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

- **Receive a copy of this authorization.**
- **Refuse to sign this authorization** and that treatment, payment, enrollment in a health plan or eligibility for healthcare benefits may not be contingent on my signing this authorization.
- **Revoke this authorization**, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s): _____

_____ | _____
Signature of Patient (or Legal Representative) | **Date**

If signed by Legal Representative:

_____ | _____
Relationship to Patient (authority to act on patient's behalf) | **Date**