CHIPPEWA VALLEY ORTHOPEDICS AND SPORTS MEDICINE

1200 Oakleaf Way STE A
Altoona, WI 54720

757 Lakeland Dr. STE B
Chippewa Falls, WI 54729

2200 Cedarcrest Dr. STE A
Rice Lake. WI 54868

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

_____ _____
Name of Patient Patient Birth Date

_____
Phone Number

_____
Street Address, City, State, WI, Zip Code

I hereby authorize:

_____
Name

_____
Street Address

_____
City, State, WI, Zip Code

_____
Phone number Fax number

To disclose my protected health Information, as described below, to:

_____
Name of Individual or Entity

_____
Street Address

_____
City, State, WI, Zip Code

_____
Phone number Fax number

Information to be released:

☐ Medical History, Examination Reports
☐ Surgical Reports
☐ X-ray Reports
☐ X-ray images
☐ Other

***Please specify what you are needing (dates of service, body part that was examined, etc.)**

_____

Purpose of the use or disclosure:

☐ At the request of the individual
☐ Other (Please specify) _____

Method of Delivery (select one):

☐ Fax to Patient (must provide fax number above)
☐ Fax to Facility (must provide fax number above)
☐ Patient Pick Up at: ☐ Altoona ☐ Chippewa Falls ☐ Rice Lake
☐ Mail to Patient (**$10.00 fee for postage and handling**)

I understand that I have the right to:

- ☐ Inspect or copy the information to be used or disclosed.
- ☐ Receive a copy of this authorization
- ☐ Revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to the authorization

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal privacy regulations.
I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

Unless otherwise revoked, this authorization will expire on: _____

_____ _____
Signature of patient Date

_____ _____
Signature of personal representative, person authorized by the patient, or other legal authority Relationship/legal authority

Updated on: 02/23/2026