



**NORTH SHORE
ORTHOPAEDICS**
S.C.

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GLENDALE OFFICE • 7545 N PORT WASHINGTON RD • GLENDALE, WI 53217-3422
(414) 351-3500 • FAX (414) 351-9063

**AUTHORIZATION AND/OR REQUEST FOR RELEASE OF
MEDICAL RECORDS TO NORTH SHORE ORTHOPAEDICS, S.C.**

I _____ Date of Birth: _____ Chart No.: _____
(PRINT - Patient's Full Name)

AUTHORIZE AND REQUEST THAT:

(Name of Party to Release Records)

(Address)

(City/State/Zip)

RELEASE THE FOLLOWING (PLEASE CHECK): _____ MEDICAL RECORDS _____ X-RAYS

OTHER (Specify): _____

Whether prepared by you or by others, and whether dated before or after the date of this authorization. Records may be requested by telephone as long as this authorization is in effect. Requests for medical records should be directed to the Medical Records Clerk.

PURPOSE OF DISCLOSURE: FURTHER MEDICAL CARE

TO: **NORTH SHORE ORTHOPAEDICS, S.C.**

 GLENDALE OFFICE
7545 N PORT WASHINGTON RD
GLENDALE, WI 53217-3422

 MEQUON OFFICE
SETON PROFESSIONAL BUILDING
13133 N PORT WASHINGTON RD
SUITE #116
MEQUON, WI 53097-2422

(Name of Party to Receive Records - Check Office Where Patient Is Being Seen)

This Authorization is effective for one year from date of signature.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. YOU HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING. REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. REVOCATION WILL NOT APPLY TO YOUR INSURANCE COMPANY WHEN THE LAW PROVIDES YOUR INSURER WITH THE RIGHT TO CONTEST A CLAIM UNDER YOUR POLICY. THE INFORMATION DISCLOSED MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY LAW. TREATMENT, PAYMENT, ENROLLMENT IN A HEALTH PLAN, OR ELIGIBILITY FOR BENEFITS IS NOT BASED ON THE PROVISION THAT YOU SIGN THIS AUTHORIZATION. YOU WILL BE GIVEN A COPY OF THIS AUTHORIZATION.

(Signature of Patient or Other Legally Authorized Person)

(If Signed by Other Legally Authorized Person, Relationship to Patient)

(Date of Signing)