PRIMARY CARE ASSOCIATES OF APPLETON, LTD

Form Completion Request

Not answering every question on this form may delay us in getting your completed form to you. You must complete and sign the "Authorization for the Disclosure of Health Information" at the bottom of this form for us to release your medical information.

Patient Name_____ Date of Birth_____ Today's Date:_____

Address:_____

Your provider's name: (doctor, nurse practioner or physician assistant)_____

Important question….Did you miss any work?_____Yes _____No _____Not applicable

- If so, what dates?_____
- Reason missed work:_____

Type of form: (i.e. disability, FMLA, camp, day care, insurance, etc.)_____

How would you like to receive your form?

_____ Mail

_____Call me when ready at this number:_____

_____Fax to this number: _____

When do you need your form?_____

Please allow 5-7 work days for form completion.

For Office Use Only

New Request	_____
Request Completed	_____
Needs Provider Signature	_____
Form Completed	_____
Sent/Faxed/Mailed and Filed	_____

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

(Photocopy or facsimile of the original authorization will be considered as valid as the original)

Information to be released from:

Primary Care Associates of Appleton, LTD
3916 N Intertech Ct
Appleton, WI 54913

Information to be released to:

_____
Name of receiver

_____
Address

_____
City/State/Zip Code

Information to Be Released:
Information needed to fill out form(s)

Need For The Disclosure:
Form needs to be completed per patient request.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Medical Records Dept. Team Leader. **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization -** I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services). **Right to Revoke This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Medical Records
Dept. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.
Expiration Date: This authorization is good until the following date(s)_____or for one year from the date signed. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: _____

DATE: _____ Reason for non-patient signature_____

(If signed by other than the patient, state relationship and authority to sign for patient i.e. parent of minor child, power of attorney for adult, etc.)