IPW | Independent Physicians of Wisconsin

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM.

I, _____, hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

Patient Information:

Patient Name: _____ Record Number: _____

Address: _____ Date of Birth: _____

Information Requested:

_____

_____

_____

Purpose of Release:

_____

_____

_____

The Information Is To Be Provided To:

Name of Person/Organization/Facility**:**

Independent Physicians of Wisconsin, LLC
West Bend Medical
W178N9201 Water Tower Place #200
Menomonee Falls, WI 53051

Telephone: 262-355-8010
Fax: 262-355-8011

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS.