AUTHORIZATION AND RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I, the signee, hereby consent to and authorize the attending physician, their assistants, therapists, and any designees of Wisconsin River Orthopaedics, Ltd. or the Surgery Center of Wisconsin Rapids, collectively Wisconsin River Orthopaedic Institute (WROI) to perform such examinations, procedures, treatments, and to administer such medications as in their opinion necessary or advisable.

I understand that the entities of WROI are not responsible for the loss of valuables such as wallets, purses, dentures, glasses, hearing aides, etc.

I request and authorize that payment of approved Medicare benefits and the benefits of other insurance plans be made on my behalf to the entities of WROI for any services furnished by facility, physician, therapist, or clinic staff. I authorize any holder of my Protected Health Information (PHI) to be released to the Centers for Medicare and Medicaid Services (CMS) and its agents, as well as any information needed to determine these benefits or the benefits payable for related services.

I permit a copy of this authorization to be used in place of the original. I understand that my Protected Health Information (PHI) is protected by law (as under current HIPAA regulations) and have been offered WROI's Notice of Privacy Practices.

I authorize WROI and its affiliates to release my PHI information, including medical and billing information, to my doctors, insurance companies, the responsible party named below and immediate family members on behalf of myself and/or dependents for the purposes of providing me with proper healthcare (treatment), to inform my family members of my condition, to inform appropriate agencies during disaster relief efforts, or where applicable by the Privacy Compliance Rule. WROI will not use PHI for the purposes of financial gain. I also authorize my referring physician offices and other healthcare entities to release all prior films and other PHI as requested by WROI for the purposes of providing appropriate healthcare. Other uses or disclosures of PHI not covered by this notice or the laws that apply to WROI will be made only with my written permission.

I may revoke my permission at any time in the future, even if I do not do so at this time. This authorization will automatically expire one year from the date of my signature below. Please sign below, that you have read and agree.

Responsible Party Signature: _____ Date: _____

Patient Name (if different from Responsible Party): _____