BrownClinic P.L.L.P.
Personal Care From The People You Know And Trust.

Patient Information

Name First _____ Middle _____ Last _____

Patient Email _____ Legal Guardian (if patient is a minor) _____

Address _____ City _____ State _____ Zip _____

Phone No. home _____ mobile _____ work _____

SS No. _____ Patient/Guardian Employer & Ph. No. _____

Spouse _____ Spouse's Employer & Ph. No. _____

OUTSIDE HOUSEHOLD, WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?

Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Phone No. home _____ mobile _____ work _____

Information concerning your care will be forwarded to your referring Doctor unless otherwise specified below.

How do you want to be contacted by your doctor? _____

Who else is authorized to speak with about your care and account? _____

Name _____ Phone No. _____

PLEASE PRESENT YOUR INSURANCE CARD & DRIVERS LICENSE TO RECEPTIONIST

Primary Insurance Company Name _____

Address _____ City _____ State _____ Zip _____

Group No. / Name _____ Policy No. _____

Phone _____ Insured Name & DOB _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Company Name _____

Address _____ City _____ State _____ Zip _____

Group No. / Name _____ Policy No. _____

Phone _____ Insured Name & DOB _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Who is financially responsible for the account? _____

Name _____ DOB _____ Phone No. _____

Please remember that some insurance pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to. This assignment will remain in effect until revoked by me in writing. A photocopy of this assessment shall be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize assignee to release all information necessary to secure the payment.

Please Sign _____ Date _____

CLINIC USE ONLY
To Physician:

Brown Clinic P.L.L.P.
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Authorization for Disclosure of Health Information

PATIENT:

Name of Patient/Previous Names _____

Birth Date _____ Medical Record No. _____

Address _____ City _____ State _____ Zip _____

AUTHORIZES:

Name of Health Care Provider/Plan/Other _____

Address _____ City _____ State _____ Zip _____

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other _____

Address _____ City _____ State _____ Zip _____

INFORMATION TO BE RELEASED:	DATE OF SERVICE:
☐ Information Necessary for Continued Care	_____
☐ History and Physical	_____
☐ Pathology Report	_____
☐ Labs	_____
☐ EKG/EMG/EEG	_____
☐ ER/UC	_____
☐ Immunizations	_____

INFORMATION TO BE RELEASED:	DATE OF SERVICE:
☐ Discharge Summary	_____
☐ Operative/Procedure Report	_____
☐ Consultations	_____
☐ Xrays	_____
☐ PT/SP/OT	_____
☐ Progress Notes	_____
☐ Other _____	

(CONTACT MEDICAL IMAGING DEPARTMENT TO OBTAIN FILMS)

IN COMPLIANCE WITH WISCONSIN AND MINNESOTA STATUTES WHICH REQUIRE SPECIAL PERMISSION TO RELEASE OTHERWISE PRIVILEGED INFORMATION, PLEASE RELEASE RECORDS PERTAINING TO:

- ☐ Alcohol Abuse or test results
- ☐ Drug Abuse or test results
- ☐ Mental Health
- ☐ Developmental Disabilities
- ☐ HIV test results, AIDS or AIDS-related disease
- ☐ Sexually Transmitted Disease
- ☐ Other _____

THIS DISCLOSURE IS BEING MADE FOR THE FOLLOWING PURPOSE(S):

- ☐ Further medical care
- ☐ Relocation/moving
- ☐ Insurance change
- ☐ At the request of an individual
- ☐ Changing physicians
- ☐ Work Comp
- ☐ Attorney/court case
- ☐ Insurance
- ☐ Other (comments) _____

REDISCLOSURE NOTICE: I understand the information used or disclosed based on this authorization may possibly be redisclosed by the recipient and/or no longer protected by Federal Privacy standards.

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 Health Information Services Dept. **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 or 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 authorizaton 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 how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Health Information Services 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 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 _____

If Signed by other than patient, state relationship and authority to do so:

☐ Parent ☐ Guardian ☐ POA for Healthcare ☐ Spouse/Adult Family Member of deceased patient _____