Wisconsin Health Fund

6200 West Bluemound Road • Milwaukee, Wisconsin 53213
(414) 771-5600 ext:3636 • Fax (414) 475-7386

Patient:

Full Name: ____ Date of Birth: ______________

Address: ______________________________ City: ______________ State: _____ Zip Code: _________

Authorized Records Released From:

Office Name: ____

Address: ______________________________ City: ______________ State: _____ Zip Code: _________

Authorized Records Released To:

Office Name: ____

Address: ______________________________ City: ______________ State: _____ Zip Code: _________

Type or Extent of Information to be Released: (Check all applicable categories)

_____ Dental records _____ Dental X-rays

I authorize records to be given to (list name of person): ____

Purpose or need for release: ____

This authorization will remain in effect until: __________________________

This authorization will be effective for dental generated to the date of signature and is valid for six months unless otherwise stated.

I understand I may revoke this authorization at any time by providing my written revocation.

____ _________________

Signature of Patient Date

(If signed by person other than patient, state relationship to patient)

Patient is: Minor _____ Incompetent _____ Deceased _____

Legal Authority: Parent or Legal Guardian _____ Next of Kin of Deceased _____

Witness: ____________________________________ Date: ____________ Time: ___________

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