3200 Shore Drive, P.O. Box 437, Marinette, WI 54143
855 S. Main Street, Oconto Falls, WI 54154
500 Roosevelt Road, Niagara, WI 54151
2353 S. Ridge Road, Suite 3, Green Bay, WI 54304

Phone: (715) 735-3187 or (888) 766-4684
Fax: (715) 735-5848

Authorization for Release of Medical Information

I, ___________________________________hereby authorize ____________________________

to release my medical information to: Northern Lights Clinic
PO BOX 437
3200 Shore Drive
Marinette, WI 54143
(715) 735-3187

Patient Name: ____

Date of Birth: __________________________Dates of Treatment: __________________________

The information to be duplicated includes:

□ History & Physical □ Pathology Reports □ Operative Report

□ Discharge Summary □ Entire Record for Time Period □ Radiology Report

□ Other: ____

The purpose of this disclosure is for:

□ Continued Care □ Insurance □ Other: _____________________________

This authorization shall be valid one year following the date of signature. However, I understand that this authorization may be revoked at any time by giving notice in writing to Northern Lights Clinic. I understand that the information may have been released in good faith prior to the date of revocation. I understand that the records may contain records concerning medical, psychiatric, alcohol, or substance abuse records. Information may also include information regarding blood alcohol levels, HIV status, AIDS diagnosis or Hepatitis results and I give permission to release this information as well.

The facility and employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. A photocopy or facsimile of this authorization shall constitute a valid authorization.

Patient Signature: ____Date: _________________

OR Time: _________________

Authorized Representative: ___________________________________ Date:_________________

Relationship to Patient: ____________________________

Witness: ____ Date:__________________

Time: __________________