Joyce's Caring Touch
2266 N Prospect Ave Suite 210
Milwaukee, WI 53202
414-841-5853 (office)
414-921-5589(fax)

Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Name _____**DOB** _____**Soc. Sec. #** _____

Address _____**Phone** _____

Information to be Released From: ☐ **Physician** ☐ **Clinic** ☐ **Hospital** ☐ **Agency**

INFORMATION TO BE RELEASED TO:
Joyce's Caring Touch
2266 N Prospect Ave Suite 210
Milwaukee, WI 53026
414-841-5853 (office)
414-921-5589 (fax)

INFORMATION TO BE RELEASED (must check all that apply)

• History and Physical	• Progress Notes	• Discharge Prior Authorization
• Discharge Summary	• MD Visit Notes	• Training Records
• Lab reports	• X-ray results	• Admission Summary
• List of current medications	• List of Diagnosis	• TB Results
• Transfer PCST to agency	• Other	

INFORMATION TO BE RELEASED FOR PURPOSE OF:

☐ Initiating Care ☐ Care Coordination ☐ Employment ☐ Emergency Preparedness

TIME PERIOD TO BE INCLUDED:

From (date) _____ **To (date)** _____ **or** ☐ **most current**

Release by: ☐ **Fax** ☐ **Mail** ☐ **Pick-up**

- ❖ *I understand that this authorization for release of information is valid for one year or date of* _____.
- ❖ *If I choose to revoke this authorization I must do so in writing.*
- ❖ *A photocopy / facsimile of this authorization shall have the same force and effect as an original.*
- ❖ *By signing this release of information, I understand that authorizing the disclosure of this information is voluntary.*
- ❖ *I also understand that I am authorizing disclosure of information protected by federal law and in accordance to HIPPA.*

_____ _____ _____
Signature *Print Name* *Date*

_____
If other than signature above, list relationship

_____ _____ _____
Witness *Print Name* *Date*