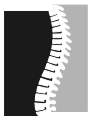

BRANKO PRPA M.D.
Spine Surgery

OFFICES:

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www.prpaspinesurgery.com
Phone: (414) 939-5447
Fax: (262) 260-8968

Aurora St. Luke's Medical
2900 W. Oklahoma Ave
Milwaukee, WI 53215

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____ Sex: M / F Phone Number: _____

I authorize the use or disclosure of the above names patients' health information as described below:

FROM:	**TO:**
Name: _____	Name: _____
Address: _____	Address: _____
City/State: _____	City/State: _____
Zip: _____	Zip: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____

FOR THE PURPOSE OF: (Check all that apply)
☐ Transfer Primary Care ☐ Continued Care ☐ Second Opinion ☐ Legal ☐ Insurance Care
☐ Personal Use ☐ Other _____

INFORMATION TO BE RELEASED: (Please be specific and enter dates of service, if known):
☐ Entire medical record _____, excluding _____
☐ Medical Record Abstract (H&P, Operative Rpt, Discharge Summary, Consults, Labs, X-Rays, Pathology)
☐ Clinic Notes (Specify clinic name) _____ ☐ Pathology Reports ☐ MRI Reports
☐ Consultation Reports _____ ☐ Medication Records_____
☐ Other (specify content) _____

I understand the information in my health record may include information relating to Sexually Transmitted Diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that if I refuse to authorize the disclosure of information, the information will not be released. A copy of this authorization will be considered as valid as the original.

This authorization expires 365 days from the date this authorization is signed unless otherwise noted_____

I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing. I understand that authorizing the disclosure of this health information is voluntary, and I can refuse to sign.

Signature of Patient (18 years or older): _____ Date: _____

Signature of Legal Representative: _____ Date: _____

Relationship to Patient: _____ Date: _____