**Correspondence Relating to Request for Release of Health Care Information**

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TO:

FROM:

DATE:

RE: (Patient Last Name, First Name, Patient D/O/B)

FILE NO.:

* In reference to your request for information regarding the above-named individual, Wisconsin statutes require that we must have the following items of an enforceable informed consent:
* Name of individual whose treatment record is being disclosed
* Purpose or need for disclosure
* Name or type of health care provider making the disclosure
* Specific type of information to be disclosed (this is a multi-disciplinary agency, please specify)
* Individual, agent or organization to which disclosure is to be made
* Time period during which consent is effective
* Signature of patient, individual or person legally authorized to give consent for the individual
* Date on which consent is signed
* A consent form, which will meet the requirements of the Wisconsin statutes when completed, is enclosed for your convenience.
* The consent form submitted is not valid for the information requested. Please have the enclosed authorization completed and return to in the enclosed envelope.
* The consent form submitted with your request has expired. Please provide a current consent form which meets the above requirements.
* We are unable to find any record of treatment for the above-named on or near the date indicated. Provide additional information please.
* Regarding Worker’s Compensation; upon review of the record it cannot be determined whether reports are reasonably related to the claim. Please provide a valid, written authorization if you wish to obtain copies of records or the date and nature of the injury that compensation is being claimed for.
* All information has been sent to you previously regarding this patient.
* Please provide an authorization with an original signature or one with a statement that indicated a reproduced copy is as valid as an original.
* Authorization is part original, part copy, please provide a valid all original or all copy authorization.
* We are unable to read the signature on authorization.
* Please further clarify legal guardianship by submitting copies of court papers, etc.
* Other:

**Please note that prepayment for copies of the requested information are required. The amount for the copies is $ . Please return your payment along with this form.**

Thank you for your cooperation. If you have any further questions, please contact of at (phone number) .

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