Northern Wisconsin Bone & Joint Center
7520 US Highway 51 S Ste A
Minocqua, WI 54548-8944

Northern Wisconsin
Bone & Joint Center

Phone: 1-888-444-CURE
Fax: 1-608-467-1393

Medical Record Processing Fee Schedule

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), the state of Wisconsin allows health care organizations to access a fee for the processing of medical records requests with the exception of those for continuing care purposes. No fee is charged for copies sent directly to another health care provider.

Below is a regulated fee schedule for the state of Wisconsin. Paper copies will incur the following fees plus postage costs.

Number of Pages	Price Per Page
1-25	$1.00
26-50	$0.75
51-100	$0.50
101+	$0.30

Medical records are available on a CD upon request. Fee for CD copy is $7.50 for records to be placed on electronic media. Must have PDF viewer.

If you would like copies of your x-rays taken at our facility, they will be given to you on a CD for a fee of $5.50

Fees are subject to change based on WI states statute administrative code section 146.83.

Medical Record Release of Information

Northern WI Bone & Joint Center
7520 Hwy 51 S, Ste A
Minocqua, WI 54548

1) PATIENT INFORMATION:

Full Name ________ Date of Birth ________ Previous Name (if applicable) ________

Address ________ City ________ State ________ Zip ________

Daytime phone ________

2) AUTHORIZES:

Northern WI Bone & Joint / Dr. Tadych 7520 US Hwy 51 S., Minocqua WI 54548
Name of Health Care Provider

3) TO DISCLOSE TO:

☐Self - Delivery Options: ☐ Pick up ☐ View on Site ☐ Mail to address above

☐To be picked up by, I hereby authorize ________ to pick up my records.
(Photo ID required.) (Full name of person)

☐Send to: ________
Name of Health Care Provider / Plan / Other

Address ________ City ________ State ________ Zip ________

Phone ________ Fax ________

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From ________ to ________

If left blank, only information from the past two (2) years will be disclosed. (month/year) (month/year)

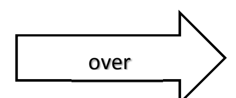
5) INFORMATION TO BE DISCLOSED:

☐ All medical records related to (specify condition, treatment, etc.): ________

☐ All billing records related to (specify condition, treatment, etc.): ________

☐ Radiology films/images (specify test): ________

☐ Specific records/information as follows: .): ________



I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED

(as defined by applicable state and federal laws):

☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health / Developmental Disabilities

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6) EXPIRATION: This Authorization is good until the following date/event: ______________________ ***Note***: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) PURPOSE (Check all that apply - Copy fees may apply):

☐ Further Medical Care ☐ Legal Investigation /Action

☐ Insurance Eligibility/Benefits ☐ Personal (at my request)

☐ Other: ____

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8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. I understand that a fax or photocopy of this form is the same as the original.

9) SIGNATURE OF PATIENT / LEGAL REP: ____

DATE: ________________________

If signed by a person other than the patient, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased

2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin/executor of deceased

☐ activated Power of Attorney for Health Care

FORM INSTRUCTIONS:

1) Fill in your identifiable information.
2) You are agreeing to authorize Northern WI Bone & Joint to release your medical information.
3) Disclosure designation: Select who you want to receive the requested medical records by using the check boxes.
4) Date Range: give us a date range that you would like us to retrieve from your records. If left blank, the last 2 years will be disclosed.
5) Information to be disclosed: select from the check boxed options and write in specifics if necessary (i.e. right knee pain visit notes or right knee x-rays.
6) Expiration: set a date for this particular disclosure.
7) Purpose: why are you requesting? Are you seeing another provider for more care? Do you have legal representation? Is it for your personal records?
8) Your rights: please read carefully.
9) Signature: should be signed by patient unless they are a minor, incompetent/incapacitated or deceased (select the boxes below if this form is not signed by the patient.

Submit this form in person, via US Mail Service or fax.

Northern WI Bone & Joint Ctr
Attn: Release of Medical Records
7520 Hwy 51 S, Ste A
Minocqua WI 54548

Fax: 608-467-1393 Attn: Release of Medical Records

For Office Use Only:

Signature/ID verified ☐Yes ☐No Completed by: ______________________________ # of pages released _________

Name / Date