

WELLNESS CENTER OF DOOR COUNTY, INC.  
312 N. 5<sup>th</sup> Avenue, P.O. BOX 85  
STURGEON BAY, WI 54235  
(920) 746-9444 fax: (920) 746-9466  
email: [info@wellnesscenterofdoorcounty.com](mailto:info@wellnesscenterofdoorcounty.com)  
[www.wellnesscenterofdoorcounty.com](http://www.wellnesscenterofdoorcounty.com)

**AUTHORIZATION TO RELEASE INFORMATION**

I, \_\_\_\_\_, DOB \_\_\_\_\_ do hereby authorize

RECORDS RELEASED FROM:

RECORDS RELEASED TO:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WELLNESS CENTER OF DOOR COUNTY  
312 N. 5<sup>th</sup> Avenue, PO BOX 85  
STURGEON BAY, WI 54235

INFORMATION TO BE RELEASED:

Hx and Physical       Pap/Pelvic/STD tests      \_\_\_\_\_ Other

PURPOSE FOR DISCLOSURE:  Further Medical Care

This authorization will expire 6 months from the date of signature, except as specified: \_\_\_\_\_ months.  
I understand that I may revoke this consent at any time by sending a written request to the Wellness Center. I understand that any release that was made prior to my revocation shall not constitute a breach of my rights to confidentiality.

\_\_\_\_\_  
Signature of Patient/legal guardian

\_\_\_\_\_  
Date

Relationship to patient if signed by person other than patient. \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Specific authorization for release of information  
Protected by state or federal law.

I specifically authorize the release of info

Relating to:  Mental Health conditions

HIV (AIDS)       Alcohol/substance abuse

Other \_\_\_\_\_

Further disclosure of any of this  
Information will require the  
Patients written consent, unless  
Otherwise permitted by law.

Signature: \_\_\_\_\_

9/06