#### Disclaimer

This Document is Copyright © 2006 by the HIPAA Collaborative of Wisconsin ("HIPAA COW"). It may be freely redistributed in its entirety provided that this copyright notice is not removed. It may not be sold for profit or used in commercial documents without the written permission of the copyright holder. This Document is provided "as is" without any express or implied warranty. This Document is for educational purposes only and does not constitute legal advice. If you require legal advice, you should consult with an attorney.

# HIPAA COLLABORATIVE OF WISCONSIN

### AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION [Individual/Patient/Client/Insured]:

mes	Birth Date	
		()
	City, State, Zip, Phone	
	DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:	
n making disclosure	Individual/agency/organization receiving information	
	Street Address	
	City, State, Zip Code	
escription of the health information I	authorize to be used and/or disclosed	
Developmental Disabilities	Alcohol &/or Drug Abuse	HIV test results
rom To	·	
OF DISCLOSURE: (Check appli		al" is sufficient]
OF DISCLOSURE: (Check appli	icable categories) urposes; "at the request of the individua	
	<b>C USED &amp;/or DISCLOSED:</b> <b>asert check boxes for specific ty</b> escription of the health information I tes, which require special permission Developmental Disabilities	TO: Individual/agency/organization receiving inform Individual/agency/organization receiving inform Street Address City, State, Zip Code CUSED &/or DISCLOSED: Insert check boxes for specific types of information; e.g. progress notes, escription of the health information I authorize to be used and/or disclosed tes, which require special permission to release otherwise privileged information planet

or eligibility, c) the provision of health care benefits on my decision to sign this authorization except regarding. a) research-related treatment, b) health plan enformment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. [Implementation Tip—identify applicable a-c and delete unnecessary provisions OR state the consequence if the individual does not sign—note, WI law requires the patient's authorization to disclose 252.15 or 51.30 records for payment purposes.]

**Right to Withdraw This Authorization -** I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to [*Enter disclosing covered entity contact*]. I am aware that my withdrawal will not be effective until received by [*Enter disclosing covered entity name*] and will not be effective regarding the uses and/or disclosures of my health information that [*Enter covered entity name*] has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. MARKETING: I understand if the [*Enter covered entity name*] uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information. [Implementation Tip—only needed if authorization is for marketing] Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect my health information or obtain copies of my health information by contacting [*Enter name of department/individual*].

**HIV TEST RESULTS:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request. [Implementation Tip—if list is available with authorization, remove "upon request."]

#### Disclaimer

This Document is Copyright © 2006 by the HIPAA Collaborative of Wisconsin ("HIPAA COW"). It may be freely redistributed in its entirety provided that this copyright notice is not removed. It may not be sold for profit or used in commercial documents without the written permission of the copyright holder. This Document is provided "as is" without any express or implied warranty. This Document is for educational purposes only and does not constitute legal advice. If you require legal advice, you should consult with an attorney.

## HIPAA COLLABORATIVE OF WISCONSIN

**REDISCLOSURE NOTICE**: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

**EXPIRATION DATE:** This authorization is good until (indicate date or event) \_\_\_\_\_\_. By signing this authorization, I am confirming that it accurately reflects my wishes.

DATE:

#### SIGNATURE PATIENT/LEGAL REP: \_

*(If signed by other than individual, state relationship with signature)* [Implentation Tip— insert check boxes to indicate legal relationships]

This authorization is prepared in conjunction with the HIPAA-COW Authorization/Informed Consent for Use and Disclosure of Health Care Information Grid that enumerates requirements of State and Federal privacy laws.

Prepared by: Susan Manning, JD, RHIA Chrisann Lemery, RHIA

Date: 02/20/03, 2/23/06