HIPAA COLLABORATIVE OF WISCONSIN
AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

[Individual/Patient/Client/Insured]:

_____ _____
Name of Individual/Previous Names Birth Date

_____ _____(_____)_____
Street Address City, State, Zip, Phone

AUTHORIZES:

_____
Individual(s)/agency/organization making disclosure

_____
Street Address

_____
City, State, Zip Code

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

_____
Individual/agency/organization receiving information

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE USED &/or DISCLOSED:
[Implementation Tip—insert check boxes for specific types of information; e.g. progress notes, lab, claims history]
The following is a specific description of the health information I authorize to be used and/or disclosed_____

_____

In compliance with WI Statutes, which require special permission to release otherwise privileged information please release records pertaining to:
[Check all that apply]

☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol &/or Drug Abuse ☐ HIV test results

☐ Other (Specify):_____

For the Following Date(s): From_____ To_____.

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)
[Implementation Tip—insert check boxes for specific purposes; "at the request of the individual" is sufficient]

☐ Further Medical Care ☐ Coordinating Care for Dependent/Spouse ☐ Insurance Eligibility/Benefits ☐ Claims Resolution

☐ Other (Specify):_____.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that [the covered entity] may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment 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 or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange 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."]**

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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.

SIGNATURE PATIENT/LEGAL REP: _____ DATE: _____

(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.

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