CHIPPEWA VALLEY EYE CLINIC, LTD.

Comprehensive Eye Care

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:

☐ Medical History, Examination, Reports ☐ Operative Reports ☐ Treatment or Tests ☐ X-Ray Reports

☐ Hospital Records/Reports ☐ Laboratory Results ☐ Prescriptions ☐ Consultations

☐ Other _____

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)

☐ 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 *Chippewa Valley Eye Clinic.* I am aware that my withdrawal will not be effective until received by *Chippewa Valley Eye Clinic* and will not be effective regarding the uses and/or disclosures of my health information that *Chippewa Valley Eye Clinic* 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. **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 *Chippewa Valley Eye Clinic.*

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.

2715 Damon Street
Eau Claire, WI 54701
715-834-8471 ph ~ 715-834-8964 fx

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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)

Patient is: ☐ Minor ☐ Incompetent ☐ Deceased

Legal Authority: ☐ Patient Legal Gaurdian ☐ Next of Kin of Deceased

☐ Other _____

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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