

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Birth Date: _____

Phone: _____ Address: _____

I authorize the following healthcare provider to make disclosure of records. **Release From:** (Who has the info to disclose)

Chippewa Valley Eye Clinic, 1110 Oakridge Drive, Eau Claire, WI 54701 Phone: 715-834-8471 Fax: 715-834-0373
OR

Provider/Facility Name _____

Address: _____

Phone: _____ Fax: _____

INFORMATION TO BE USED &/or DISCLOSED: ALL Medical History / Examination / Reports Operative Reports
 Treatment or Tests Laboratory Results Prescriptions Consultations Other _____

DATE(S) TO DISCLOSE: ALL From _____ To _____

AUTHORIZATION VALID THROUGH: _____ / _____ / _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

Further Medical Care Transferring Care Change of Insurance Other (Specify): _____

Disclosure of Protected Health Information Release To: (To whom the information should be disclosed)

Chippewa Valley Eye Clinic, 1110 Oakridge Drive, Eau Claire, WI 54701 Phone: 715-834-8471 Fax: 715-834-0373
OR

Provider/Facility Name _____

Address: _____

Phone: _____ Fax: _____

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 Chippewa Valley Eye Clinic 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.

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 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.

Re-disclosure 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.

*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.

By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

Printed name of Guardian or Authorized Representative

Relationship / Capacity to patient