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: 2715 Damon Street, 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: 2715 Damon Street, 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 **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed name of Guardian or Authorized Representative **Relationship / Capacity to patient**