AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Fax (920)496-4737

P.O. Box 19070
Green Bay, WI 54307-9070

PATIENT INFORMATION

Name: ______________________________
Last First M.I.

Birth Date: ______________ Maiden/Other Name: ______________

Telephone Number: ______________ Chart Number: ______________

AUTHORIZES DISCLOSURE BY:

☐ **Prevea Clinic**
or By:

____
Name of Health Care Provider/Plan/Other

____
Street Address

____
City, State, Zip Code

DISCLOSURE OF HEALTH INFORMATION TO:

☐ **Prevea Clinic**
or To: ExamOne
800 NW Chipman Rd. / Suite 5900
POBox 2340
Lee's Summit, MO 64063-1149

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed*

☐ Office Notes (Dates) ______________
☐ Immunization / shot records
☐ Physical Therapy Notes (Dates) ______________
☐ Other (Specify) ______________
☐ Lab Reports
☐ X-ray reports
☐ Electrocardiogram Reports
☐ Pre-employment physical exam
☐ Pregnancy Records
☐ Worker's Comp Records (Dates) ______________

DISCLOSURES REQUIRING SPECIAL CONSENT: **In compliance with Wisconsin Statutes, which require special permission for release of otherwise privileged information, please release related to the following:**

☐ Mental Health Treatment
☐ AIDS / AIDS related diagnosis
☐ Treatment of Alcohol or Drug Abuse
☐ Developmental disabilities
☐ HIV test Results*

FOR THE FOLLOWING DATES: From: ______________ To: ______________

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

☐ Continuing Care
☐ Disability Determination
☐ Personal Use
☐ Other: ______________
☐ Insurance / Claim Purposes
☐ Legal Investigation

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed - I understand that I have the right to inspect or receive a copy (with possible fee) of the health information I have authorized to be used or disclosed by this form. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that Prevea 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 Prevea Clinic. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. ***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.
****WI Statutes 51.30 and 252.15** requires patient authorization to disclose health information for payment purposes.

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 the following date(s) __________ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT /LEGAL REP.: ______________________________ **DATE:** ______________
(If signed by other than patient, state relationship and authority to do so.)

File behind miscellaneous tab

MO-639 R 5/03