NorthEast Wisconsin Community Clinic

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Today's Date: ____________________ E#: (Office Use) ____________

Patient's Name: ____________________ DOB: ____________

Patient's Address: ____________________ Phone #: ____________

I AUTHORIZE:	TO EXCHANGE PHI WITH:
N.E.W. Community Clinic 610 N. Broadway Green Bay, WI 54303 P: (920) 437-7206 F: (920) 436-3876 (Medical) F: (920) 437-9480 (Behavioral Health) F: (920) 489-8233 (Dental)	____________________ Individual or Organization ____________________ ____________ Address Phone Number ____________________ City, State, Zip Code

FOR THE PURPOSE OF:

☐ Continuing Care ☐ Personal Use ☐ Case Management ☐ Other: ____________

i.e., at the request of the client for their own use, continuing care, case management, authorizing continued treatment, payment benefits, etc. The type and amount of information to be used or disclosed for the following dates:

From: ____________________ To: ____________________

☐ AODA and/or Psychiatric Discharge Summary which may include HIV information

☐ AODA and/or Psychiatric Reports

☐ Psychological Reports

☐ Lab/X-Ray Reports

☐ Social Worker/Case Manager Reports

☐ Progress Notes

☐ Miscellaneous Reports (Please Specify): ____________________

☐ Medication List

☐ PT/OT/RT Reports

☐ Physical Examinations

☐ HIV Testing Results/AIDS Related

☐ Treatment Plan

The information may be shared via:

☐ In Person ☐ By Phone ☐ By Fax ☐ By Mail ☐ By Email

YOUR RIGHTS REGARDING AUTHORIZATION

Right to inspect or receive a copy of the health information to be used or disclosed: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact N.E.W. Community Clinic. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. N.E.W. Community Clinic will not condition treatment on the completion of this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I understand that this information may be released electronically.

EXPIRATION DATE: This authorization is effective for one (1) year from the date signed unless otherwise indicated, to be less than 1 year.

Please be specific. Date____________ (Optional)

____________________ ____________ ____________

Signature of Patient/Person Authorized Relationship Date

____

Print Patient/Person Authorized

This confidential copy of the N.E.W. Community Clinic case record may not be duplicated, copied, or disclosed without the informed consent of the individual to whom the information pertains.

Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)

I confirm that this release is still valid, and would like to extend the release until: ____________

New Date

Signed: ____________________ **Date:** ____________ **Witness:** ____________

Revoking of ROI: I request that this Release of Information Authorization be revoked on: ____________

Signature: ____________________ Date