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**OPPORTUNITY FOR PATIENT TO OBJECT TO
KEWAUNEE COUNTY'S
USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR
CERTAIN PURPOSES**

Patient's Name:	_____		
	Last	First	Middle
Home Address:	_____		

Home Telephone:	_____		Date of Birth: _____

I understand that Kewaunee County has a Notice of Privacy Practices (the "Notice"). I hereby acknowledge that by my review of the Notice and this form, Kewaunee County has informed me that my health information may be used or disclosed for one or more of the three purposes described below.

PURPOSES:

1. For Involvement of Others in My Care. Disclosure of my Protected Health Information to a family member, other relative, close personal friend, or any other person identified by me, that is directly relevant to that person's involvement with my care or payment for my care.

2. For Notification of My Location, General Condition or Death. Disclosure of my Protected Health Information to notify (or assist in the notification of) my family member (or personal representative or other person responsible for my care) of my location, general condition or death.

3. For Disaster Relief Efforts. Disclosure of my Protected Health Information to a public or private entity authorized to assist in disaster relief efforts in order to coordinate efforts to notify (or assisting in the notification of) my family member (or personal representative or other person responsible for my care) of my location, general condition or death.

I acknowledge that Kewaunee County has provided me with the opportunity to: 1) agree to the uses or disclosures described above; 2) request restrictions on some of these uses or disclosures; or 3) prohibit these uses or disclosures. By my signature below, I hereby agree to the following (**Please check one of the boxes below**):

- the use and disclosure of my health information for all of the three purposes described above.

- the use and disclosure of my health information only for the following purposes: (**Please circle the applicable purpose(s)**):
1 (Involvement of Others in My Care)
2 (Notification of My Caregiver)
3 (Disaster Relief Efforts)

- the use and disclosure of my health information for all of the three purposes described above, subject to the following restriction(s): _____

_____.

- By my signature below, I hereby prohibit the use and disclosure of my health information for all of the above listed purposes.

Signature of Patient (or Personal Representative)

Date of Signature

Printed Name of Personal Representative

Relationship to Patient