

KEWAUNEE COUNTY

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name: _____

Last

First

Middle

Home Address: _____

Home Telephone: _____

Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED: _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By signing my name next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- Information about a Mental Illness or Developmental Disability _____
- Psychotherapy Notes _____
- Information about HIV/AIDS Testing or Treatment _____
(including the fact that an HIV test was ordered, performed or reported,
regardless of whether the results of such tests were positive or negative)
- Information about Venereal Disease _____
- Information about Substance (i.e., alcohol or drug) Abuse _____
- Information about Abuse of an Adult with a Disability _____
- Information about Sexual Assault _____
- Information about Child Abuse and Neglect _____
- Information about Genetic Testing _____

RECIPIENT: Name of person or class of persons to whom Kewaunee County may disclose my health information: _____

Address of the recipient or where my health information should be delivered: _____

TERM: This Authorization will remain in effect:

From the date of this Authorization until the _____ day of _____, 200__.

Until Kewaunee County fulfills this request.

Until the following event occurs: _____.

Other: _____.

PURPOSE: I authorize Kewaunee County to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization]_____.

I understand that once Kewaunee County discloses my health information to the recipient, Kewaunee County cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Kewaunee County may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Kewaunee County; except, however, if my treatment at Kewaunee County is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Kewaunee County may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Kewaunee County's Departmental Privacy Office at the address listed below. The revocation will be effective immediately upon Kewaunee County's receipt of my written notice, except that the revocation will not have any effect on any action taken by Kewaunee County in reliance on this Authorization before it received my written notice of revocation.

I may contact Kewaunee County's Departmental Privacy Office by mail at _____ or by telephone at _____.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Kewaunee County to use or disclose my health information in the manner described above.

Signature of Patient

Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of
Personal Representative

Description of
Authority

Date

If Organization has requested this Authorization provide a copy of signed Authorization to the patient.