NORTHERN WISCONSIN BONE & JOINT CENTER
Authorization for Use & Disclosure of Health Information

Patient Name Authorizing Consent: _____ **DOB**: : _____

Above listed patient hereby authorizes: **THE DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:**

_____ _____
Full Name Relationship to Patient named above

INFORMATION TO BE USED &/or DISCLOSED: (*check the boxes that you would like to give access to)*

☐ All health information listed below

☐ All visit notes

☐ All lab results

☐ All claims/billing history

☐ Oral, written, verbal communications, voice mail, appointment verification.

☐ Allowed to be present in the exam room while I am being treated and my care is discussed.

OR

The following is a specific description of the health information I authorize to be used and/or disclosed:_____

_____

_____

*In compliance with WI Statutes, which require **special permission** to release otherwise privileged information please release records pertaining to:*

[Check all that apply]

☐ Mental Health ☐ Developmental Disabilities

☐ Alcohol &/or Drug Abuse ☐ HIV test results

☐ Other (Specify):_____

For the Following Date(s): From_____ To_____.

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

☐ *At the request of the individual* ☐ Further Medical Care

☐ Coordinating Care for Dependent/Spouse ☐ Insurance Eligibility/Benefits

☐ Claims Resolution

☐ Other (Specify):_____

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 Northern Wisconsin Bone & Joint Center 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 Northern Wisconsin Bone & Joint Center. I am aware that my withdrawal will not be effective until received by Northern Wisconsin Bone & Joint Center and will not be effective regarding the uses and/or disclosures of my health information that Northern Wisconsin Bone & Joint Center 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 may arrange to inspect my health information or obtain copies of my health information by contacting Northern Wisconsin Bone & Joint Center. 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. 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: _____ or until _____
(enter date) (enter ascertainable event)

By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: _____ DATE: _____
(If signed by other than individual, state relationship with signature)

Turn over for instructions

FORM INSTRUCTIONS:

- **Patient Authorizing Consent:** Print your full name here.
- **DOB:** full date of your birth.
- **Disclosure of Protected Health Information:** Select who you want to have access to your health records (if any). Typically this form is filled out giving spouses, children or significant others access to records.

NOTE: This does not need to be completed for other doctors or our office to access your records.

- **Information to be Use&/or Disclosed:** select from the check boxed options and write in specifics if necessary in the provided area.
- **Purpose for Need of Disclosure:** Check the appropriate box. Typically it will be *"at the request of the individual (you)."*
- **Expiration Date:** This **MUST** be completed by either designating a specific date that this authorization will be valid for **OR** and Event (ex: until death, for 1 year etc.)
- **Signature:** should be signed by patient unless they are a minor, incompetent/incapacitated or deceased (select the boxes below if this form is not signed by the patient.
- **Date:** enter the date of signature.