AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

[Individual/Patient/Client/Insured]:

_____ _____
Name of Individual/Previous Names Birth Date

_____
Student I.D. #

AUTHORIZES:

SNC Health and Wellness Services
Individual(s)/agency/organization making disclosure

100 Grant Street
Street Address

De Pere, WI, 54115
City, State, Zip Code

DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO: ☐ **Health Provider** ☐ **Parents** ☐ **Professor** ☐ **Student Affairs Staff** ☐ **Self** ☐ **Counseling/Mental Health Agency** ☐ **Other**

_____
Individual/agency/organization receiving information

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE USED OR DISCLOSED:

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

☐ General Health Assessment ☐ Medications ☐ Medical Diagnosis ☐ Treatment Plan ☐ Lab tests/X-Ray ☐ Immunization ☐ Other:_____

Pursuant to Wisconsin law requires, I specifically request the disclosure of the following records:
[Check all that apply]

☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol And Other Drug Abuse ☐ HIV test results

☐ Other (Specify):_____

For the Following Date(s): From_____ To_____.

PURPOSE OF DISCLOSURE: (Check applicable categories)

☐ Coordinating Care ☐ Insurance Eligibility/Benefits ☐ Claims Resolution ☐ At the Request of the Individual

☐ Further Medical Care [necessary for Alcohol &/or Drug Abuse per 42 CFR s. 2.2]

☐ 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 Health &Wellness Services 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 *Health &Wellness Services*. I am aware that my withdrawal will not be effective until received by Health & Wellness Services and will not be effective regarding the uses and/or disclosures of my health information that Health & Wellness Services 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 Health & Wellness Services**.**

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 (indicate date or 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)