AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

Name of Individual/Previous Names _____ Birth Date _____

Street Address _____ City, State, Zip, Phone _____(____)_____

AUTHORIZES:

Trillium Midwifery Services
48210 Lewig Lane
Wauzeka, WI 53826
Home/Office Phone: (608) 379-3099
Fax: (608) 492-3524

☐ **TO OBTAIN FROM:** ☐ **TO DISCLOSE TO:**

_____
Individual/agency/organization

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE USED &/or DISCLOSED:

☐ Prenatal Record(s) ☐ Operative Reports regarding: _____

☐ Labor and Delivery Record(s) ☐ Postpartum Record(s) ☐ Labs ☐ Radiology Reports (x-rays)

☐ Specific Records/Information as follows: _____

_____

In compliance with WI Statutes, which require special permission to release otherwise privileged information please release records pertaining to: [Check all that apply]

☐ HIV test results ☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol &/or Drug Abuse

☐ Other (Specify):_____

For the Following Date(s): From_____ (month/year) To_____ (month/year). ***If left blank, only information from the past 2 years will be disclosed.***

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

☐ Further Medical Care ☐ At the request of the individual

☐ 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 Trillium Midwifery Services or the corresponding party 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 Trillium Midwifery Services. I am aware that my withdrawal will not be effective until received by Trillium Midwifery Services and will not be effective regarding the uses and/or disclosures of my health information that Trillium Midwifery Services or the corresponding party 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 Trillium Midwifery Services at the number listed above**. I understand that I may be charged a fee for record copies. 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 upon request.

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 for one year or until (indicate date or event) _____. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE CLIENT/LEGAL REP: _____ **DATE:** _____

(If signed by other than individual, state relationship)