

**ONEIDA COMMUNITY HEALTH CENTER
WISCONSIN CONSENT**

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's patient health care records and HIV test results to carry out treatment, payment activities, and health care operations, (b) our disclosure of the individual's patient health care records to carry out treatment, payment activities, and health care operations, and (c) our disclosure of the individual's patient health care records and HIV test results to family members or others involved in their care or payment for their care.

This form should not be used to obtain written permission for the disclosure of HIV test results.

SECTION A:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ E-mail: _____

Patient Identification: _____ Social Security Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

SECTION B: The uses and disclosures being authorized.

Facility Directory and Persons Involved in Care. By checking the boxes below, you indicate your consent to:

Our listing of my general condition in our facility directories (residents of our skilled nursing facility only).

Our disclosure of your patient health care records to the following family members or other persons, including those involved in your care or payment for that care.

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, Xrays, or other similar forms of protected health information.

Our Use of Medical Information: By signing this form, you will consent to our use of your patient health care records and to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.



Our Disclosure of Medical Information. By signing this form, you will consent to our disclosure of your patient health care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice. Your HIV test results, if any, can only be disclosed to persons and/or under circumstances specified in Wisconsin Statutes § 252.15(5)(a). A listing of those persons and/or circumstances is available upon request.

Our Communications With You. Please check the boxes below to indicate your consent:

- We may send correspondence to your home.
- We may call you at home.
- We may leave a message on your answering machine or voicemail at home/work.

SECTION C: Revocation.

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Office listed below. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Contact Office: Oneida Community Health Center – Medical Records
525 Airport Road, Oneida, WI 54155
(920) 869-2711
(920) 869-6820 (fax)
www.oneidanation.org/healthcenter

INDIVIDUAL’S SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the use and disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the individual, complete the following:
Personal Representative’s Name: _____
Relationship to Individual: _____

Include completed form in the individual’s records.