ONEIDA COMMUNITY HEALTH CENTER

AUTHORIZATION

Purpose: This form is used for an individual to authorize use or disclosure of the individual's protected health information for the purposes stated.

SECTION A: Psychotherapy notes.

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

SECTION B: Individual authorizing use and/or disclosure.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Date of Birth: _____ Social Security Number: _____

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

No Conditions: This authorization is voluntary. We will not condition your treatment on receiving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION C: The use and/or disclosure being authorized.

Purpose of this Authorization:

◯ At request of individual (or the individual's personal representative).

◯ For the following purposes:

Protected Health Information to Be Use and/or Disclosed: Specifically and meaningfully describe the protected health information that this authorization will allow to be used and/or disclosed:

Entities Authorized to Use or Disclose: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who will be authorized to make use of and/or to disclose the protected health information described above:

From: Oneida Community Health Center **Phone:** (920)869-2711

Address: P.O. Box 365 **City, State, Zip:** Oneida, WI 54155

Entities Authorized to Receive and Use: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, whom this authorization will allow to receive and use the protected health information described above:

To: _____ Phone: _____

Address: _____ City, State, Zip: _____

SECTION D: Expiration and revocation.

Expiration: This authorization will expire (complete one):

◯ On _____

◯ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the Contact Office listed below. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation.

Contact Office: Oneida Community Health Center – Medical Records
PO Box 365, Oneida, WI 54155
(920) 869-2711
(920) 869-6820 (fax)

INDIVIDUAL'S SIGNATURE.

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

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual:_____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's records.
Send copy to the Privacy Official.