

Oneida Comprehensive Health Division

Oneida Community Health Center
Behavioral Health Services
Anna John Resident Centered Care Community
Employee Health Nursing



Authorization to Use and Disclose Medical Information

Oneida Comprehensive Health Division

Name of Patient: _____

Birthdate: _____

Home Phone Number: _____

Social Security Number: _____

Cell Phone Number: _____

Work Phone Number: _____

By signing this form, I authorize Oneida Comprehensive Health Division to use and disclose my medical information to:

Name

- _____ Dental Medical* Optical Pharmacy (Drop off/Pick Up Only)
- _____ Dental Medical* Optical Pharmacy (Drop off/Pick Up Only)
- _____ Dental Medical* Optical Pharmacy (Drop off/Pick Up Only)
- _____ Dental Medical* Optical Pharmacy (Drop off/Pick Up Only)
- _____ Dental Medical* Optical Pharmacy (Drop off/Pick Up Only)
- _____ Dental Medical* Optical Pharmacy (Drop off/Pick Up Only)

*Information released under Medical is Provider Notes of Medical History, Examination; Surgical Reports; Progress or Discharge; Hospital Records Including Reports; Tests and Results; Allergy Records; Immunizations; Prescriptions; Radiology Reports; Consultations; Laboratory Reports; Appointments, Medical Supplies and Purchased Referred Care.

In addition, I specifically authorize the release of records pertaining to:

Mental Health HIV (AIDS) Substance Abuse Developmental Disabilities

Other (Specify) For the Following Date(s): _____

COMMUNICATIONS: Please check the boxes below to indicate your consent:

Mail Call Leave Message Other (Specify) _____

HOW THIS FORM MAY AFFECT ME AND MY RIGHTS:

Right to Revoke Authorization. I understand that I have the right to revoke this authorization, except to the extent that Oneida Comprehensive Health Division has already used or disclosed my medical information in reliance of this authorization. I understand that my revocation is effective only if it is in writing. To revoke my authorization, I understand that I must send a written request for revocation to Oneida Comprehensive Health Division medical records staff.

Right to Inspect and Copy My Medical Information. I understand that I have the right to inspect and copy my medical information in Oneida Comprehensive Health Division records. I understand that to inspect and copy medical information, I must submit my request in writing to Oneida Comprehensive Health Division medical records staff. If I request a copy of the information, I understand that Oneida Comprehensive Health Division may charge a reasonable cost-based fee in accordance with applicable law to fulfill my request. I understand that Oneida Comprehensive Health Division may deny my request to inspect and copy in certain very limited circumstances. If I am denied access to medical information, I may request that the denial be reviewed in certain circumstances.

I Am Not Required to Sign this Authorization. I understand that I may refuse to sign this authorization may or may not affect my ability to obtain treatment at Oneida Comprehensive Health Division. However, I also acknowledge that I have agreed to sign this authorization.

Mailing Address: P.O. Box 365, Oneida, WI 54155
<https://oneida-nsn.gov/resources/health/>

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525 Airport Rd., Oneida, WI 54155
2640 West Point Rd., Green Bay, WI 54304
2901 S. Overland Rd., Oneida, WI 54155
701 Packerland Dr., Green Bay, WI 54303

Phone: (920) 869-2711 or 1-866-869-2711
Phone: (920) 490-3790 or 1-888-490-2457
Phone: (920) 869-2797
Phone: (920) 405-4492

Fax: (920) 869-1780
Fax: (920) 490-3883
Fax: (920) 869-3238
Fax: (920) 405-4494

This authorization will remain in effect until I chose to revoke.

Signature of Patient

Signature of Legal Representative

Signature Date: _____

If signed by a Legal Representative, complete the following:

The individual is: a minor legally incompetent or incapacitated deceased

Legal authority: parent* legal guardian next of kin/executor of deceased activated POA for Health care

*By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order.