

Obstetrical & Gynecological Care

Oakridge Medical Building

1110 Oakridge Drive

Eau Claire, WI 54701

www.obgycare.com

fax 715-834-9833

OB-GYN Clinic of Eau Claire
Irfane M. Khatib, MD
715-836-9020

Eau Claire Women's Care
Donna Schoenfelder, MD
Steven Stenzel, MD, FACOG
Jamie Lamm MSN, APRN, BC
715-834-9998

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT:

Name of Individual/Previous Names

Birth Date

Street Address

City, State, Zip, Phone ()

AUTHORIZES (to whom records are being released from)

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

Individual(s)/agency/organization making disclosure

Individual/agency/organization receiving information

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

INFORMATION TO BE USED AND/OR DISCLOSED:

Medical History Examination Reports Surgical Reports Pathology Reports X-Ray Reports Lab Reports
 Pregnancy Record Entire Record Other: _____

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

Mental Health Coordinating Care for Dependent/Spouse Alcohol and/or Drug Abuse HIV test results

FOR THE FOLLOWING DATE(S): FROM _____ TO _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

Further Medical Care Coordinating Care for Dependent/Spouse Insurance Eligibility/Benefit Claims Resolution
 Other: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Rights to Receive Copy of This Authorization – I understand that if I sign this authorization, I will be provided with a copy of this authorization upon request.

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that (the covered entity) may not condition treatment, payment, enrollment in a health plan or eligibility for 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 our Health Information Coordinator. I am aware that my withdrawal will not be effective until received by the previously mentioned clinic and will not be effective regarding the uses and/or disclosures of my health information that the clinic has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition or 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 our Health Information Coordinator.

HIV Test Results – I understand my HIV test results may be released without authorization to persons/organizations that have access under State law.

Re-disclosure 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 in effect for 6 months from the date of signature below unless otherwise stated. _____
By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient

Date

Signature of personal representative, persons authorized by the patient or other legal authority

Relationship/legal authority