AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

INDIVIDUAL:

_____ _____/_____/_____
Name Birth Date

_____ (___)_____
Street Address City State Zip Code Phone

ENTITY AUTHORIZED TO USE AND/OR DISCLOSE HEALTH INFORMATION:

Caledonia Fire Department Address: 6900 Nicholson Road, Caledonia WI 53108

ENTITY AUTHORIZED TO RECEIVE AND/OR USE HEALTH INFORMATION:

_____
Individual/agency/organization receiving information

_____ _____
Street Address City, State, Zip Code

INFORMATION TO BE USED AND/OR DISCLOSED:

The following is a specific description of the health information I authorize to be used and/or disclosed: _____

_____

Including (check all that apply): ☐ Patient Care Report ☐ Other (Specify): _____

NEED OR PURPOSE OF DISCLOSURE: (Check all applicable categories)

☐ At the request of the individual ☐ Further medical care ☐ Coordinating care for dependent/spouse

☐ Insurance eligibility/benefits ☐ Claims Resolution ☐ Disability Determination

☐ 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 Caledonia Fire Department ("Department") 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 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 the Department's Privacy Officer at the above address. I am aware that my withdrawal will not be effective until received by the Department and will not be effective regarding the uses and/or disclosures of my health information that the Department has made prior to receipt of my withdrawal statement. **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 the Department's Privacy Officer at the above address or cfdsec@caledoniawifd.com. **HIV Test Results -** I understand that, to the extent held by the Department, 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 until (indicate date or event) _____. If no expiration date is indicated, this Authorization shall expire one year from the date signed below. By signing this authorization, I am confirming that it accurately reflects my wishes.

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: _____