Hemophilia Outreach Center

HIPAA AUTHORIZATION
For Use or Disclosure of Protected Health Information

INDIVIDUAL'S NAME

Legal Name: _____ Contact Phone #_____

Address_____

Date of Birth: _____ Medical Record #:_____

The following organization is authorized to make the disclosure:

Hemophilia Outreach Center
2060 Bellevue Street
Green Bay, WI 54311-5622

The following individuals or organizations are authorized to receive disclosures:

- □ Myself only_____
- □ Parent(s) _____
- □ Spouse_____
- □ Legal Guardian(s) _____
- □ Others (list individually):

Name: _____

Address: _____

Contact Phone Number: _____Relationship:_____

Name: _____

Address: _____

Contact Phone Number: _____Relationship: _____

The type of information to be used or disclosed is as follows (Check all that apply):

- □ Appointment information-including dates, times, and provider's name
- □ Physician appointment questions or results (i.e. drug refill information, referrals)
- □ Lab or other diagnostic results
- □ Financial information
- □ Medical information EXCEPT: _____
- □ Can leave messages on answering machine or by email
  EXCEPT: _____
- □ Other: _____

Patient Assistance Programs

- □ I authorize HOC staff to work on my behalf and utilize my information to initiate or maintain my participation in manufacturer related co-pay assistance programs.

Information related to the following will not be released without the appropriate consent form signed:

Mental health testing	Developmental disability	STD's
AIDS/AIDS related treatment	HIV test results	

Right to Receive a Copy of this Authorization
I understand that this authorization is voluntary and I will receive a copy of this signed authorization at my request.

No Conditions
I understand that Hemophilia Outreach Center may not condition my treatment or services based on the provision that I authorize this disclosure of my protected health information.

Effect of Granting this Authorization
I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules.

Expiration and Revocation

Expiration: This authorization will expire (chose one):

□ On _____/_____/_____

□ Until I choose to revoke it

Revocation: I understand that I have the right to revoke this authorization at any time by providing verbal or written notice of revocation to Hemophilia Outreach Center by calling 920-965-0606 or sending it to 2060 Bellevue Street, Green Bay, WI 54311. I understand that the revocation will not apply to information that has already been released due to this authorization.

INDIVIDUAL'S SIGNATURE

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

_____ _____

Signature Date

If personal representative signs this authorization on behalf of the individual, complete the following:

_____ _____

Personal Representative's Name Relationship to Individual

VERBAL AUTHORIZATIONS OBTAINED

Date:	Reason:
_____	_____
_____	_____
_____	_____
_____	_____