HIPAA COLLABORATIVE OF WISCONSIN
AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

[Individual/Patient/Client/Insured]:

_____	_____
Name of Patient/Previous Names	Birth Date
_____	_____(_____)_____
Street Address	City, State, Zip, Phone
_____	_____
Name of Employee (if different)	Relationship to Patient
_____	_____(_____)_____
Street Address	City, State, Zip, Phone

AUTHORIZES:	**DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:**
_____	_____
Patient's Health Care Provider	Name, Title, University of Wisconsin-
_____	_____
Street Address	Street Address
_____	_____
City, State, Zip Code	City, State, Zip Code

INFORMATION TO BE USED &/or DISCLOSED:
The following is a specific description of the health information I authorize to be used and/or disclosed:

only information requested in the attached Physician Certification for Family or Medical Leave

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 ☐ Developmental Disabilities ☐ Alcohol &/or Drug Abuse ☐ HIV test results

☐ Other (Specify):_____

For the Following Date(s): From_____ To_____.

DISCLOSURE IS NEEDED TO DOCUMENT: (Check applicable categories)

☐ Employee's need for medical leave due to his/her own serious health condition

☐ Employee's need for family leave to care for the patient (parent, spouse, or child with a serious health condition).

☐ 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. However, the employee may be denied leave under the federal or state Family and Medical Leave Act if adequate documentation of the patient's serious health condition is not provided.
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 my health care provider. I am aware that my withdrawal will not be effective until received by my health care provider and will not be effective regarding the uses and/or disclosures of my health information that my health care provider 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 or obtain copies of the health information submitted to document the employee's eligibility for leave under the federal or state Family and Medical Leave Act by contacting the employee's University of Wisconsin Staff Benefits Office..
HIV TEST RESULTS: I understand my HIV test results may be released without authorization to persons/organizations that have access under s. 252.15(5)(a) of the Wisconsin statutes.

HIPAA COLLABORATIVE OF WISCONSIN

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) _____. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____
(If signed by other than individual, state relationship with signature)

This authorization is prepared in conjunction with the HIPAA-COW Authorization/Informed Consent for Use and Disclosure of Health Care Information Grid that enumerates requirements of State and Federal privacy laws.

Prepared by: Susan Manning, JD, RHIA
Chrisann Lemery, RHIA

Date: 02/20/03
Revised: UW Office of Staff Benefits 5/19/03