**AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name Birth Date

\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ Street Address City, State, Zip Phone

**AUTHORIZES:** Professional HomeCare Providers (PHP)

**DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:** The PHP Job Board & Nurses in Independent Practice seeking employment

**INFORMATION TO BE USED and/or DISCLOSED:**

\_\_Client name \_\_County of residence \_\_address \_\_contact telephone number \_\_age

 \_\_Nursing care needs (i.e. trach, vent, G tube, CVL, # hours needed, shift, etc)
\_\_Medical Diagnosis \_\_Medical history
\_\_Plan of Care

\_\_Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 the start of nursing care To: ongoing.

**PURPOSE FOR NEED OF DISCLOSURE:** (Check applicable categories)
\_\_Arranging home care, hiring nursing staff \_\_Coordinating Care for Dependent/Spouse

\_\_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 PHP may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

**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 PHP. I am aware that my withdrawal will not be effective until received by PHP at PO BOX 270239 Hartford, WI 53027 or WisconsinPHP@gmail.com and will not be effective regarding the uses and/or disclosures of my health information that PHP 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 PHP at PO BOX 270239 Hartford, WI 53027 or WisconsinPHP@gmail.com.

**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 PHP is notified in writing that the ad is to be removed. By signing this authorization, I am confirming that it accurately reflects my wishes.

**SIGNATURE CLIENT OR LEGAL REP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_**

 *(If signed by other than individual, state relationship with signature)*

**RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**