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 139 E. Wisconsin Ave. Oconomowoc, WI 53066 or PHP.Wisconsin@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 139 E. Wisconsin Ave. Oconomowoc, WI 53066 or PHP.Wisconsin@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: _____