

**OPPORTUNITY FOR PATIENT TO OBJECT TO
FOREST COUNTY'S
USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR
CERTAIN PURPOSES**

Patient's Name: _____		
Last	First	Middle
Home address: _____		

Home Telephone: _____		Date of Birth: _____

I understand that Forest County has a Notice of Privacy Practices (the “**Notice**”). I hereby acknowledge that **I have received a copy of Forest County's Notice** and have had the opportunity to review the document and to ask questions, which have been answered to my satisfaction.

I also acknowledge that by my review of the Notice and this form, Forest County has informed me that my health information may be used or disclosed for one or more of the three purposes described below. At this time, I have the opportunity to object to the use of my Protected Health Information for these purposes.

PURPOSES:

1. **For Involvement of Others in My Care.** Disclosure of my Protected Health Information to a family member, other relative, close personal friend, or any other person identified by me, that is directly relevant to that person's involvement with my care or payment for my care.
2. **For Notification of My Location, General Condition or Death.** Disclosure of my Protected Health Information to notify (or assist in the notification of) my family member (or personal representative or other person responsible for my care) of my location, general condition, or death.
3. **For Disaster Relief Efforts.** Disclosure to my Protected Health Information to a public or private entity authorized to assist in disaster relief efforts in order to coordinate efforts to notify (or assisting in the notification of) my family member (or personal representative or other person responsible for my care) of my location, general condition or death.

I acknowledge that Forest County has provided me with the opportunity to: 1) agree to the uses or disclosures described above; 2) request restrictions on some of these uses or disclosures; 3) prohibit these uses or disclosures. By my signature below, I hereby agree to the following.

(Please check one of the boxes)

- the use and disclosure of my health information for all of the three purposes described above

- The use and disclosure of my health information only for the following purposes:
(Please circle the applicable purpose(s)):
1 (Involvement of Others in My Care
2 (Notification of My Caregivers
3 (Disaster Relief Efforts)

- the use and disclosure of my health information for all of the three purposes described above, subject to the following restriction(s):

_____.

- By my signature below, I hereby prohibit the use and disclosure of my health information for all of the above listed purposes.

Signature of Patient (or Personal Representative)

Date of Signature

Printed Name of Personal Representative

Relationship to Patient

If you would like clarification of the information found on this form, employees please contact Forest county's Privacy Officer Using the contact information listed below. Patients, please contact Forest County Department of Social Services Director, 200 E. Madison St. Crandon, WI 54520; phone number: (715) 478-3351.

If you are not satisfied with Forest County's response to your request, please contact the Forest County Department of Social Services Director or County Clerk.



FOREST COUNTY AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name: _____
Last
Middle
First

Home Address: _____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED:

MY HIGHLY CONFIDENTIAL INFORMATION:

By signing my name next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- Information about a Mental Illness or Developmental Disability _____
- Psychotherapy Notes _____
- Information about HIV/AIDS testing or treatment _____
 (including the fact that an HIV test was ordered, performed, or reported, Regardless of whether the results of such tests were negative or positive)
- Information about sexually transmitted infection _____
- Information about Abuse of an Adult with a Disability _____
- Information about Sexual Assault _____
- Information about Child Abuse and Neglect _____
- Information about Genetic Testing _____

RECIPIENT: Name of the person or class of person to whom Forest County may disclose my health information:

Address of the recipient or where my health information should be delivered:

TERM: This authorization will remain in effect:

- From the date of this Authorization until the _____ day of _____, 20_____.
- Until Forest County fulfills this request
- Until the following event occurs: _____
- Other: _____

PURPOSE: I authorize Forest County to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization]

I understand that once Forest County discloses my health information to the recipient, Forest County cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Forest County, except, however, if my treatment at Forest county is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, which case Forest County may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a completed Forest county Written Notice of Revocation form to Forest County's Privacy Officer at the address listed below. The revocation will be effective immediately upon Forest County's receipt of my written notice, except that the revocation will not have any effect on any action taken by Marinette County in reliance on this Authorization before it received my written notice of revocation.

I may contact Forest County, County Clerk by mail at 200 E. Madison St. Crandon, WI 54520 or by telephone at 715-478-2422.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Forest County to use or disclose my health information in the manner described above.

Signature of Patient

Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal Representative

Description of Authority

Date