City of Wauwatosa Health Department

Authorization for Use & Disclosure of Health Information

This form is used to document verification of the identity and authority of a person or entity, unknown to you, before you grant access or disclose protected health information

[Individual/Patient/Client/Insured]

Name of Individual/Previous Names:	
Date of Birth:	
Street Address:	
City, State, Zip:	
Phone Number:	
E-mail Address:	

Authorizes:

City of Wauwatosa Health Department
7725 W North Ave
Wauwatosa, WI 53213

Disclosure of Protected Health Information To:

Your Name:	
Your Street Address	
City, State, & Zip Code:	

Indicate Request Type (Select one):

☐ E-mail (subject to e-mail security)
☐ Postal Mail
☐ In person (unable to fulfill in-person requests until further notice)

Information to be used &/or disclosed:
The following is a specific description of the health information I authorize to be used and/or disclosed: COVID-19 Lab Result

For the Following Date(s) From: 05/219/2020 to 05/19/2021

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 the Wauwatosa Health Department may not condition treatment, payment, enrollment in health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of healthcare that is solely for the purpose of creating PHI for disclosure to a third party. 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 City of Wauwatosa Health Department. I am aware that my withdrawal will not be effective until received by City of Wauwatosa Health Department and will not be effective regarding the uses and/or disclosure of my health information that City of Wauwatosa Health department has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to consent a claim under the policy or the policy itself. Marketing: I understand if the City of Wauwatosa Health Department uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information. 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 the Health Officer or her designee of the Wauwatosa Health Department.

Disclosure 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 05/19/2021. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature Patient/Legal Rep:_____ Date:_____

Signature must be printed, electronic signatures will not be accepted by the City of Wauwatosa Health Department