



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name: _____

ID #: _____

Date of Birth: _____

Description of the information to be used and/or disclosed (Be Specific): _____

Purpose for use and/or disclosure of this information: _____

I understand that certain medical information falls into Restricted Protected Data Classes. My initials below indicate that this information may also be released. If I do not initial, the information will not be disclosed.

- | | | |
|-----------------------|------------------------------------|--------------------------|
| ____ Abuse or Neglect | ____ Abortion | ____ Alcohol Abuse |
| ____ Drug Abuse | ____ Contraceptive Issues | ____ Genetic Testing |
| ____ HIV | ____ Mental Health | ____ Reproductive Health |
| ____ Sexual Assault | ____ Sexually Transmitted Diseases | |

I would like WINhealth Partners to discuss my personal health information described above with:

Name: _____ Date of Birth: _____ Relationship: _____

This authorization is valid until (Indicate Date): _____

I have requested the use and/or disclosure of my personal health information as listed above and I understand that my personal health information may no longer be protected if it has been disclosed to a person who is not bound by the HIPAA Privacy Rule. WINhealth Partners may not condition treatment, payment, enrollment or benefits eligibility on my provision of this authorization. I understand that I may revoke this authorization unless WINhealth Partners has already taken action based on this authorization or if the authorization was obtained as a condition of obtaining insurance coverage. I understand that I must provide a written request to revoke this authorization.

Signature (If not the member, verification of your relationship to the member and authority is required.)

Today's Date

Signature (Parent or Guardian if member is under 18)

Today's Date

WINhealth Partners Use Only

Authorization is complete? Yes No

Authorization is clear? Yes No

If someone other than the member is requesting this use and/or disclosure, the relationship and authority has been verified by (Indicate means): _____

Signature

Date