Aurora Health Care®

Aurora Occupational Health and Wellness

Site: Manty Health and Wellness

FOR OFFICE USE ONLY

MRN / Chart#: _____

Verbal Consent to view Personal Health Information

N/A _____ Date: N/A
Patient Signature

N/A _____ Date: N/A
Provider Signature

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) **Patient Information:** _____
Name of Patient / Previous Name

_____ (_____) _____
Date of Birth Area Code / Telephone Number

_____
Address City/State/Zip

2) **Persons/Organizations Authorized to *Disclose* Patient's Health Information:**
Name & Address of Service Provider *(Stamp)*:

Aurora BayCare Employer Services
Manty Health and Wellness
3509 Dewey Street
Manitowoc, WI 54220

3) **Persons/Organizations Authorized to *Receive* Patient's Health Information:** ☐ Self; or

City of Manitowoc
Name of Health Care Provider / Plan / Other

900 Quay Street
Street Address

Manitowoc, WI 54220
City, State, Zip

4) **Health Information to be Disclosed:** *(Check applicable information.)*
☒ Client Service Abstract *(See back of this Authorization for definition.)*
☐ Other _____

Check here if you do not want Human Immunodeficiency Virus (HIV) test results to be disclosed: ☐

5) **Purpose for Disclosure:** *(Check applicable categories)*
☒ Employment Requirements
☐ Other _____

6) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION ARE SET FORTH ON THE BACK OF THIS AUTHORIZATION.**

7) **Expiration Date:** This Authorization is good until the following date(s)/event: _____ .
If no date or event is specified, this Authorization will expire one (1) year from the date signed.

Note: The Occupational Health services that you receive from Aurora Health Care, Inc. ("Aurora") are provided for the purpose of disclosing the results to your employer or other third party. Refusal to sign this Authorization may result in a refusal by Aurora to provide you with the specific Occupational Health services (non-treatment related) that have been requested.

REDISCLOSURE NOTICE: I understand that if the person(s)/organization(s) listed above are not governed by Federal privacy laws, the health information disclosed as a result of this Authorization may be redisclosed by the recipient and no longer be protected by such laws.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

8) **Signature of Patient/Legal Rep:** X _____ **Date:** X _____
Relationship or Authority to Act for the Patient X _____
(If you are signing as a parent of the minor patient listed above, you are declaring that you have not been denied physical placement of the child because such placement would endanger the child's physical, mental, or emotional health.)

9) **Employee Witness (required only when patient is not physically able to sign his/her entire signature):**

Signature: N/A **Title:** N/A **Date:** N/A

4) **CLIENT SERVICES ABSTRACT** may include records related to the following, if these services were provided by Aurora Occupational Health and Wellness:

- Progress notes, medical history, consultations, radiology reports, EKG, pathology reports, procedure reports, medication list, therapy evaluations and notes
- Results of physicals, and any information provided in conjunction with a physical
- Drug tests
- Breath, blood, or urine alcohol tests
- Spirometry tests
- Respiratory fitness tests
- Immunizations and vaccinations
- Audiometric tests
- Lab results
- Other screenings performed for the purpose of determining employment or related to work place surveillance.

6) **OUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

Right to Inspect or Copy: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this Authorization.

Right to Receive Copy of Authorization: I understand that if I agree to sign this Authorization, which I am not required to do, I will be provided with a signed copy of this Authorization.

Right to Refuse to Sign Authorization: I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. Unless allowed by law, my refusal to sign this Authorization will not affect my ability to obtain treatment from Aurora Health Care. ***However, I also understand that the occupational health services that I receive from Aurora are provided for the purpose of disclosing the results to my employer or other third party. Refusal to sign this Authorization may result in a refusal by Aurora to provide me with the specific occupational health services (non-treatment related) that have been requested.***

Right to Revoke Authorization: I understand that written notification must be presented to the Medical Records Department to cancel this Authorization. I understand that my withdrawal will not be effective as to uses and/or disclosures of health information already made in reliance on this Authorization.