Please describe in detail purposes for use/disclosure of each piece of protected health information (The statement "at the request of the individual" is a sufficient description of the purpose if you do not wish to elaborate. Please place a different date next to each use/disclosure in necessary):

_____

_____

Information will be sent via regular First Class Mail unless a space below is checked authorizing us to send via E-mail, over the phone and/or fax. Permission to send via E-mail, phone and/or fax is authorized. I understand the information sent in this manner is not secure and agree to hold Whitman County, the receiving party and/or authorized representatives blameless for any misdirection that may occur exposing protected information.

Please send the above listed information via: _____E-mail _____Fax _____ Phone

- I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of HIV (AIDS) virus, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnoses, testing or treatment if related to the authorization above.

- I understand that this authorization can be revoked or rescinded upon written request to the disclosing party. However the revocation will not have any affect on any action the entity took before it received the revocation.

- I understand that I may see and copy this form, and the information described, if I ask for it.

- This is not a condition for health care benefits, and I am not required to sign this form to receive my health care benefits (treatment, payment, enrollment).

- Information used or disclosed to the authorized party is subject to re-disclosure and no longer protected by the Privacy Rule. You may seek assurances from the recipient to extend the protections of this authorization.

Unless otherwise revoked or rescinded in writing to the disclosing party, this authorization will remain in full force and effect until, _____20 _____.

_____ _____

Signature of Employee or Authorized Representative Date

_____ _____

Signature of Witness Date

_____

Relationship or status if signed by anyone other than employee (parent, legal guardian, etc.)

* Protected Health Information (PHI) is any individually identifiable information transmitted or maintained in any form or medium (electronic or otherwise). Identifiable information may include demographic, financial, medical/health, and/or social data.

WCLIB #25-B