Authorization to Use and Disclose Health Information

PATIENT INFORMATION

Last Name _____ First Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ Previous Name (if any) _____

PURPOSE OF REQUEST (check all that apply)

☐ Further Medical Care ☐ Insurance Eligibility / Benefits ☐ Other _____

☐ Legal Investigation/Action ☐ Personal Use

INFORMATION TO BE DISCLOSED

Dates:
From _____ to _____

If blank, information from two (2) years prior to the execution date below will be disclosed.

☐ All Records *(including all testing, treatment, and billing records)*

☐ Billing Records Only ☐ Other: _____

The following information **WILL NOT** be released unless specifically checked below:

☐ HIV test results and related treatment ☐ Substance use treatment

☐ Sexually transmitted or other communicable diseases ☐ Mental health or developmental disabilities

☐ Genetic

DISCLOSE FROM

☐ Versiti Illinois, Inc.
(f/k/a Aurora Area Blood Bank d/b/a Heartland Blood Centers

☐ Versiti Indiana, Inc.
(f/k/a Central Indiana Regional Blood Center)

☐ Versiti Michigan, Inc.
(f/k/a Michigan Blood)

☐ Versiti Wisconsin, Inc.
(f/k/a BloodCenter of Wisconsin, Inc.)

DISCLOSE TO

Name _____

Company _____

Address _____

City _____ State _____ Zip _____

☐ Send via facsimile to:

Attention _____ Fax Number _____

☐ Send via email to:

Attention _____ Email Address _____

EXPIRATION DATE

This Authorization is valid until the following date / event: _____

If blank, this Authorization will expire one (1) year from the date of signature below.

YOUR RIGHTS & AURTHORIZATION

By signing below, I certify that I am the Patient identified above, or an individual who is legally authorized to sign this Authorization on the Patient's behalf. I understand that I have the right to inspect and receive the health information that I have authorized to be used and/or disclosed above by this Authorization. I understand that I may be charged a fee reflecting Versiti's costs in responding to this Authorization to the extent permitted by applicable law. I understand that Versiti may not condition treatment, payment, enrollment or eligibility for benefits upon execution of this Authorization unless the services are being provided solely for the purpose of disclosing the information to a third party. I may revoke this Authorization by notifying the Versiti Privacy Officer in writing at the address below. However, my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I understand that information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the Authorization. I hereby authorize the use and disclosure of my information as provided in this Authorization.

Signature _____ Print Name _____ Date _____

If signed by a person other than the Patient, please complete the following two (2) items:

1. Patient is: ☐ a minor ☐ legally incompetent ☐ legally incapacity ☐ deceased
2. Person signing is Patient's: ☐ Parent (and has not been denied physical placement or had parental rights terminated)
   ☐ Legal Guardian ☐ Activated Power of Attorney for Health Care ☐ Next of Kin / Executor

Send completed form to: Versiti, Inc. | 638 North 18th Street | Milwaukee, Wisconsin 53233 | Attn: Privacy Officer

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