Polk County Health Department
100 Polk County Plaza, Suite 180, Balsam Lake, Wisconsin 54810

Consent for Uses and Disclosures of Protected Health Information
Perinatal Health Programs

RE: ____ Birth Date: ____________________
(Name of Patient)
Address: ____

This will authorize the Polk County Health Department to share with and obtain health information from:

____
(Name)
____
(Address)
For the following dates: From__________________To_______________________

Patient/guardian initial next to information to be disclosed

____ Prenatal/OB History _____ Prenatal Progress Notes _____ Laboratory Reports

____ X-ray/Ultrasound Reports _____ Postpartum Records _____ Medication List

____ Other (specify):____

I understand I am required to consent to uses and disclosure of my protected health information for treatment, payment and health care operations, in accordance with laws which protect my privacy and control the confidentiality of that information.

This means that Polk County Health Department (PCHD) may: **(1)** use my protected health information to coordinate care within the Agency and with others involved in my care, such as my attending physician. The agency also may disclose my protected health care information to individuals outside the Agency involved in my care including family members, pharmacists, suppliers of medical equipment or other health care professionals. **(2)** Use my protected health information for billing and disclose it to my health insurance company or governmental agencies that request information in connection with claims filed for care received from the agency. **(3)** Use and disclose my protected health information for activities that are considered health care operations. These operations include: Quality assessments and improvement activities; activities designed to improve health or reduce health care costs; professional review and performance evaluations; accreditation, certification, licensing or credentialing activities.

I understand that PCHD has prepared a Privacy Notice which provides a more complete description f how my protected health information is used and disclosed to others and what uses and disclosures require further authorization for me. I understand that I will be provided with a copy of the Notice at the time of admission or receiving this consent.

I understand that I have the right to request that PCHD restrict how my protected health information is used or disclosed to carry out treatment, payment and health care operations. This is further described in the Privacy Notice. The agency is not required to agree to my requested restrictions, but if they do, the restriction is binding.

I understand that I may revoke this consent in writing except to the extent that the agency has already taken actions in reliance on it and that I may do so by providing written notice to the Public Health Supervisor. I also understand that if I revoke this consent, the agency has the right to refuse to provide further treatment.

I consent to the uses and disclosures of my protected health information as described above.

Patient's Signature: ____ Date: ____________________________

Print Name: ____

If patient is a minor, Parent/Guardian Signature: ____