Southeastern Idaho Public Health

AUTHORIZATION TO RELEASE WIC INFORMATION

CLIENT INFORMATION

Client Name: _____ *(Last) (First) (M.I.)*

Former Name(s): _____

Date of Birth: _____

HEALTHCARE PROVIDER/INDIVIDUAL RELEASING INFORMATION

Name: Southeastern Idaho Public Health

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

RECIPIENT OF INFORMATION

Healthcare Provider/Individual: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

AUTHORIZATION FOR RELEASE OF WIC INFORMATION

I authorize the release of my WIC-related records, including but not limited to:

• WIC program participation records • Nutritional assessments • WIC benefits and services received • Income eligibility documentation • Appointment history • Health screenings related to WIC participation

UNDERSTANDING & AGREEMENT

- This WIC-related information may be used for WIC program coordination, continued care, eligibility verification, or other WIC-related purposes.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- Information disclosed may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I have the right to revoke this authorization in writing at any time; however, revocation is not effective for actions already taken in reliance on this authorization.
- This authorization is valid for one year unless revoked in writing.

SIGNATURE & AUTHORIZATION

Printed Name of Client or Personal Representative: _____

Relationship to Client: _____

Signature of Client or Personal Representative: _____ Date: _____

Please bring the completed form and your identification to your nearest SIPH office location.
Office location information can be found at https://siphidaho.org/locations.php

Southeastern Idaho Public Health

I, [_____], hereby attest that the request for the use or disclosure of protected health information (PHI) related to reproductive health care is not for any of the prohibited purposes as outlined by the HIPAA Privacy Rule to Support Reproductive Health Care Privacy. Specifically, this request is not intended to:

- Conduct a criminal, civil, or administrative investigation into, or impose criminal, civil, or administrative liability on, any person for the act of seeking, obtaining, providing, or facilitating lawful reproductive health care.
- Identify any person for the purpose of conducting such an investigation or imposing liability.

I acknowledge and understand the requirements and prohibitions set forth in the HIPAA Privacy Rule and commit to adhering to these standards.

Penalties for False Attestation:

I acknowledge that knowingly and in violation of HIPAA, obtaining or disclosing individually identifiable health information under false pretenses, or making material misrepresentations about the intended use of the requested PHI, will subject me to criminal penalties. These penalties can include fines and imprisonment as specified under federal law.

By signing below, I affirm that the information provided in this attestation is true and correct to the best of my knowledge.

_____ _____

Signature Date

_____ _____

Staff Witness Signature Date

Date Sent_____ Sent by_____ Date Received_____ Received by_____

7.2024