UW Health
Department of Psychiatry

Wisconsin Psychiatric Institute & Clinics

Mail to: Health Information Management
8501 Excelsior Drive
Madison, WI 53717
Fax: (608) 203-4580

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. Patient Information

Name – Last, First, MI		
Street Address		
City	State	Zip Code
EPIC Number	Birthdate	Phone No.

2. Information to be Disclosed. (Please check only one box)

- ☐ Records pertaining to: _____
- ☐ Complete copy of official medical record
- ☐ Other (describe): _____

3. Disclosed BY:

Name – (e.g. Health Facility, Physician…) WISCONSIN PSYCHIATRIC INSTITUTE & CLINIC		
Address 6001 RESEARCH PARK BLVD		
City MADISON	State WI	Zip Code 53719-1176

4. Disclosed To:

Name – (e.g. Insurance Company, Lawyer, Physician, Patient…)		
Address		
City	State	Zip Code

5. Purpose or need for disclosure. (Please check all applicable categories)

☐ further medical care ☐ payment of insurance claim ☐ legal investigation
☐ application for insurance ☐ vocational rehabilitation ☐ patient use
☐ disability determination
☐ deposition ☐ transfer care to another physician ☐ other: _____

6. This authorization will remain in effect until the above disclosure(s) have been completed unless you specify that this authorization will be effective for an additional time period. (*To specify an additional time period, please check the box below and indicate date. NOTE that if you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.*)

☐ Other specific expiration date: _____ (mm/dd/yy)

****PLEASE SEE REVERSE FOR FURTHER INFORMATION****

In accordance with the conditions listed above and on the reverse side of this form, I authorize the use and/or disclosure of my medical information. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and/or HIV test results, with the following exception(s):

Exception(s): _____

_____

Signature of Patient

_____

Date (mm/dd/yy)

If signed by person other than patient, state relationship and authority to do so. (See reverse for information about signatures.)

Relationship: _____
Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased
Legal authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Spouse of Deceased
☐ Health Care Agent: _____
☐ Personal Representative of Deceased
☐ Other: _____

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ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

UW Health Care providers (including providers with the University of Wisconsin Hospital and Clinics, the University of Wisconsin Medical Foundation, and certain units of the University of Wisconsin-Madison) honor a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Release of Information: The information released may be obtained from the medical record of WISPIC. It may be obtained from multiple paper-based or electronic-based forms (as applicable). It may include data elements from outside sources that are embedded in tables and documents. Copies released from Health Information Management include medical records only. Copies of billing records must be requested from the UW Health Patient Business Services.

Federal HIPAA Privacy Rules: These federal rules indicate when your protected health information may be used or disclosed without your authorization. Please see our Notice of Privacy Practices for additional information.

Wisconsin Right to Privacy: Under Wisconsin law, you have the right to be free from unreasonable invasions of privacy. Wisconsin's "Right of Privacy" statute prevents individuals from using your name, portrait, or picture for advertising or trade purposes without first obtaining your written authorization.

No Obligation to Sign: You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, UW Health Care Providers may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation: You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to: WISPIC- Health Information Management, 8501 Excelsior Drive, Madison, WI 53717.

Re-release: If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect: You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the patient accounting or medical records department of the UW Health facility (hospital or clinic) where you have received care.

Copying Fees: If you are requesting disclosure/release of medical information to other hospitals, clinics, or physicians for further medical care, no copying fees will be charged. You must pay for copies you request for other purposes.

Signatures: Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact UW Health – Health Information Management, 8501 Excelsior Drive, Madison, WI 53717, (608) 263-6030, Option3.