UW Health
Department of Psychiatry

**Wisconsin Psychiatric Institute & Clinics**
6001 Research Park Boulevard
Madison, WI 53719-1176
608/263-6100
608/262-9246 FAX

# AUTHORIZATION FOR VERBAL COMMUNICATION AND/OR TO LEAVE VOICE MAIL MESSAGES

**1. Patient Information**

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

**2. Information to be Disclosed.** Verbal communication only- no copies of records provided. The individual(s) listed in box #3 below have my permission to answer questions about and to discuss orally all aspects of my health information with the other individual name in box #3.

**3. Communication Between:** **AND**

| | | | | | |
|---|---|---|---|---|---|
| Name – (e.g. Health Facility, Physician…)<br>WISCONSIN PSYCHIATRIC INSTITUTE & CLINIC | | | Name – (e.g. Insurance Company, Lawyer, Physician, Patient…) | | |
| Address<br>6001 RESEARCH PARK BLVD | | | Address | | |
| City<br>MADISON | State<br>WI | Zip Code<br>53719-1176 | City | State | Zip Code |

**AND/OR**

**Leave Voice Mail at the Following Phone Number** (includes all type of voice mails unless limited below): _____

Limit types of voicemail to:_____

**5. Purpose of Communication:(Please check all applicable categories)**

☐coordination of 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 for one year from signature unless otherwise indicated below:**

☐ Indefinite ☐ Ends on (date) _____

****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):

**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 the University of Wisconsin Hospitals 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.

**Verbal Communication Only.** This authorization allows for verbal communication between WISPIC and the designated person on this form. It does not allow for copies of medical records to be released.

**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 service 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:

Wisconsin Psychiatric Institute and Clinics, 6001 Research Park Blvd., Madison, WI, 53719.

**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.

**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 Health Information Services at 608-826-6798.

**Voice Mail Messages.** UW Health Care Providers (including the University of Wisconsin Hospitals and Clinics, the University of Wisconsin Medical Foundation, and certain units of the University of Wisconsin-Madison) and their staff recognize confidentiality as a very important part of your relationship with them. To protect your confidentiality, they will not routinely leave messages on your personal messaging system (voice mail or answering machine or with your spouse, family members or any other individual) unless you specifically give your permission to do so. This authorization may be used to share this information in the manner that you specify.