STAFF INSTRUCTIONS FOR COMPLETING AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

- NOTE that if an authorization is needed for disclosure of a patient's medical information for purposes of fundraising or marketing, a separate form is required. Such forms are available at the Marketing & Public Affairs web page of the UW Health intranet.
- Item #2a (Records to be released from the record of): specify if records to be released are those for services provided at a UWMF clinic or at UWHC sites. A detailed listing of what clinics are associated with UWHC and UWMF can be obtained by accessing the website www.uwhealth.org. This information is located in the Patient and Visitors section. Obtaining Your Medical Records, and then Obtaining Medical Records: UW Health Clinics Listing.
- Item #2b (Information to be disclosed): description must be specific enough so that the patient can understand what information he or she is permitting to be used. Thus, if "Other" box is used, description must be reasonably detailed. Please select one format in which you would like to receive the records.
- Item #2c (Radiology Images): indicate if all Radiology images are needed or specific images relating to particular studies or dates.
- Item #3 (Disclosed By): indicate the specific person(s) or class(es) of persons within the entity who will be permitted to disclose the information to outside parties.
- Item #4 (Disclosed To): indicate the specific person(s) or class(es) of persons outside the entity who will be permitted to receive the information.
- Item #5 (Purpose): indicate any and all purposes for disclosure
- Item #6 (Expiration): if "Other expiration event" is selected, the event must be one that is related to the patient (e.g., termination of patient's treatment, patient's death) or to the purpose for the authorization (e.g., if the authorization is for disability determination, the authorization might end when the determination has been finalized). Ordinarily, a specific date is preferable.
- Signatures: in general, a patient age 18 or older is the only person with legal authority to sign this form. For patients younger than 18, generally the patient's parent or legal guardian must sign on behalf of the patient. There are many exceptions, however, to these general rules. For example:
  - If the patient has a guardian of the person, the form may be signed by the patient's guardian or temporary guardian. If there is no guardian, and if two physicians have determined that the patient is incompetent, the form may be signed by the health care agent named in the patient's power of attorney.
  - If the patient is authorizing the use of HIV test results, he or she is permitted to sign this form regardless of age. If the patient is under the age of 14, a parent or guardian may sign on his or her behalf. If the patient is age 14 or older, a parent or guardian may not sign on his or her behalf.
  - If the patient is authorizing the use or disclosure of medical records involving treatment for mental illness, developmental disabilities, alcoholism or drug dependence, the patient is permitted to sign this form if he or she is age 14 or older. If the patient is between the ages of 14 and 18, a parent or guardian may sign on his or her behalf. If the patient is under the age of 14, a parent or guardian must sign.
  - For deceased patients, this form may be signed by the patient's surviving spouse or personal representative. If there is no surviving spouse or personal representative, immediate family members may sign. For this purpose, immediate family members are limited to adult children, parents, grandparents, and adult brothers and adult sisters of the deceased patient and their spouses.
  - All individuals signing for use or disclosure of medical information on behalf of a patient must state their relationship to the patient and may be required to provide proof of legal authority to permit the use or disclosure of the medical information.
  - For information about signatures in other situations or answers to questions about these issues, please contact your supervisor, the Director of Health Information, and/or the Privacy officer.
- The patient must be given a copy of the signed authorization form if the Authorization was initiated from within a UW Health Care Provider (UW Hospitals and Clinics, UW Medical Foundation, or UW-Madison) as opposed to the patient or a third party.

Health Information Management
8501 Excelsior Drive
Madison, WI 53717

University of Wisconsin Hospital and Clinics (UWHC)
University of Wisconsin Medical Foundation (UWMF, UW Health Physicians)
UW Health Rehabilitation Hospital

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. Patient Information

Name- Last, First, MI		
Street Address	City	State / Zip
Medical Record Number (if known)	Birthdate	Phone Number

2a. Records to be released from the record of (Please check only one box):
☐ UW Hospital and Clinics (UWHC) ☐ UW Medical Foundation Clinics (UWMF) ☐ Both UWHC and UWMF ☐ UW Rehab Hospital
☐ Other: ______________________

2b. MEDICAL RECORDS to be Disclosed (Please check only one box)
☐ Comprehensive overview of chart (contains all discharge summaries, all outpatient notes, all pathology reports, and all clinic summaries, x-ray reports, EKG and lab reports). **Note: Radiology Images/Films must be requested separately below and will be mailed from the Medical Imaging department. See section 2c.**

☐ Records pertaining to: ______________________________ Other (describe):______________________________
(dates or conditions)

☐ Complete copy of official medical record

Format for Records: ☐ Paper **OR** ☐ DVD (requires PDF viewer) **Please check only one box. If both formats are needed, submit a separate authorization for the other format. Please note, if a format is not selected, records will be in paper format.**

2c. RADIOLOGY IMAGES to be Disclosed from (Please check only one box):
☐ UW Hospital and Clinics (UWHC) ☐ UW Medical Foundation Clinics (UWMF) ☐ Both UWHC and UWMF ☐ UW Rehab Hospital

2d. RADIOLOGY IMAGES to be Disclosed: ☐ All radiology images ☐ Images pertaining to: ______________________
(dates and/or studies)

3. Disclosed By: ☐ UW Health (or):

Name – (e.g. Health Facility, Physician…)		
Address		
City	State	Zip Code

4. Disclosed To:

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

5. Purpose or need for disclosure - may be released electronically. (Please check all applicable categories)
☐ further medical care ☐ payment of insurance claim ☐ legal investigation
☐ application for insurance ☐ vocational rehabilitation ☐ patient use
☐ disability determination ☐ 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. (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 or event (specify): ______________________________(mm/dd/yyyy)

PLEASE SEE NEXT PAGE FOR FURTHER INFORMATION

In accordance with the conditions listed above and on the next page of this form, I authorize the use and/or disclosure of my medical information. I understand that there may be a charge for copies. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results, unless I limit the disclosure to exclude the following:

____

Signature of Patient ____________________________________ **Date:** ________________(mm/dd/yyyy)
If signed by person other than patient, state relationship and authority to do so.
(See next page for information about signatures.)

UW Health Release Documentation

Relationship: ____
Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Spouse of Deceased
☐ Health Care Agent ______________________________
☐ Personal Representative/Domestic Partner of Deceased ☐ Other __________

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 UWHC and UWMF. 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.

Sending Authorizations to UW Health: Authorizations for most UW Health Clinics can be mailed to **UW Health-Health Information Management, 8501 Excelsior Drive Madison, WI 53717**. See a detailed listing of clinics that release their own records on www.uwhealth.org. this information is located in the Patient and Visitor section, Obtaining Your Medical Records, and then Obtaining Medical Records for all UW Health sites.

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: UW Health - 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.

Multiple Formats for Release of Medical Records (Paper vs DVD): You may request records in either paper format or on DVD, however only one format will be released per authorization. You will be asked to submit a separate request for each format if both formats are desired (and may be charged for each request).

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, Option 3.