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

Authorization for Verbal Communication and/or to Leave Voice Mail Messages

This does not authorize release of copies of medical records – Use UWH #1280490 Authorization for Release of Medical Information

1. Patient Information

Name – Last, First, MI		
Street Address		
City	State	Zip
Medical Record Number (if known)	Date of Birth	Phone Number

2. Information to be Disclosed: Verbal communication only re: patient's care – no copies of medical records provided

3. Verbal Communication Between:

______________________________ **and:** Name: ______________________________
(list name of healthcare facility or specific health care provider/staff member. Listing "UW Health" will cover all UW Health locations)
(list first and last name of person(s) to whom your confidential information may be disclosed, such as a community social worker)

AND/OR

Leave VOICE MAIL at the Following Phone Number(s) ______________________________
______________________________ (voice mail includes any information, unless limited below):
(See back of form for notice regarding voice mail messages)

Limit voice mail only to information specified: ______________________________

AND/OR

Leave MESSAGE WITH AN INDIVIDUAL who answers the phone at the number provided above.
Please specify:
☐ Anyone ☐ Name(s) of authorized individual(s): ______________________________

4. Purpose of Communication: Continued Care, unless specified: ______________________________

5. This authorization will expire in one year from signature unless otherwise indicated below:

☐ Other specific expiration date or event (specify): ______________________________ (mm/dd/yyyy)

****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, sexually transmitted infection, and/or HIV test results unless I limit the disclosure to exclude the following:

____

Signature of Patient/Representative ______________________________Date: ____________(mm/dd/yyyy)

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

Print Name: ______________________________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 the University of Wisconsin Hospital and Clinics (UWHC), the University of Wisconsin Medical Foundation (UWMF), 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.

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.

Verbal Communication Only. This authorization allows for verbal communication (both in person and on the telephone) between UWHC or UWMF and the designated person(s) on this form. It does not allow for copies of medical records to be released.

Voice Mail Messages. UW Health Care Providers 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.

No Obligation to Sign. You are not under any 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 to the following address below:

- **UW Health Information Management:** 8501 Excelsior Drive, Madison, WI 53717 or fax number 608-203-4588

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 UW Health - Health Information Management, 8501 Excelsior Drive, Madison, WI 53717, or call (608) 263-6030, Option 3.