Tips for Use of Authorization for Release of Verbal Communication AND Exchange of Written Information

PURPOSE: To ensure authorization is on file for current and future sharing of information between those listed in Sections 2 and 3 only

Examples for use (but not limited to):

- School issues (ADD, IEP, asthma or other chronic conditions) communicated with and released to school staff
- Working with payers to certify/pre-approve services
- Coordination of community/social services (excluded from continuity of care purposes which doesn't require an authorization)
- Coordination of medical services where special authorization is required: Mental Health, AODA, HIV test results where both verbal AND written authorization is needed

Examples **NOT** for use:

- **NOT INTENDED FOR HIM (Health Information Management) TO IMMEDIATELY RELEASE COPIES** – ONLY THE PERSON LISTED IN SECTIONS 2 AND 3 MAY SHARE
- Provider to provider exchange of PHI (does not require authorization)
- For the sole purpose of release of copies of PHI
  - Use form UWH#1280490-DT Authorization for Release of Medical Information
- For the sole purpose of authorizing verbal communication
  - Use form UWH# 1280490V-DT Authorization for Verbal Communication and/or to Leave Voice Mail Messages
- 'General catch all authorization' to capture any and all type of authorization needed

Form Completion Tips:

Section 1 - Use label with MRN and DOB, if not already pre-populated when printing from Cadence

Section 2 - Check either UW Health or a particular clinic/unit or specific person authorized to exchange information

- Least Restrictive: Check UW Health (covers all UW Health locations)
- Moderately Restrictive: List clinic/unit which allows all appropriate staff from that clinic/unit to exchange information (allows for coverage within the clinic)
- Most Restrictive: List an individual person (limits the exchange for that person only)

Section 3 - Enter name of organization/person authorized to receive/exchange information with that listed in Section 2

- Least Restrictive: Organization
- Moderately Restrictive: Smaller section within an organization
- Most Restrictive: Individual person (including first and last name)
- Full address should be included to allow for exchange of PHI
- Phone number is only required when authorized to communicate via telephone and/or leave voice mail messages
- **NOTE:** Only one person/organization may be listed per authorization. If multiple people/organizations are desired, an authorization is required for each one, except for mother/father from same household

Sections 4 and 5 include what type(s) of information can be shared - These boxes are pre-checked as both situations must apply in order to use this authorization

- Section 4 – (**Must Be Completed**) Written: Can be defined by condition/diagnosis (Asthma, ADD, Lung Cancer), date range (past 5 years), or other (specific forms/tests/procedures, etc.)
- Section 5 – Verbal: Two-way communication

Section 6 - Additional options for voice mail - Check box if patient authorizes voice mail messages to be left at the number listed in Section 3

- If patient authorizes leaving detailed voice mail on the patient's own voice mail, the Authorization for Verbal Communication and/or to Leave Voice Mail Messages authorization (UWH #1280490V-DT) should be used instead of this form
- Authorization includes any information to be left on voice mail, unless patient specifies on the authorization such limitations (example: No lab results, no OB appointment information, etc.)

Section 7 – Purpose of disclosure - Care Coordination is prepopulated as a default. If other reason, please enter

Section 8 – Authorization expiration - Standard expiration date will be one year from date of signature unless a new date is entered – if a longer period of time is requested by the patient, a five year range is a good timeframe to use

- **NEW:** The option of Indefinite has been removed in order to reduce the risk of unknown authorization over a long period of time (patient forgets about an indefinite authorization)

Authorization paragraph:
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 the patient chooses to limit the information authorized.

- To do that, they must list the limitations in the space provided.

Signature of Patient/Representative: Signed by person legally authorized to sign

Signature of Guardian - Guardianship is a legally authorized designation – see FYI flag and scanned document for appropriate legal papers

- Stepparent cannot sign unless legal papers are on file

Date – Enter the date in which the patient/representative/guardian signed the authorization
Patient is/Legal Authority – Complete if Guardian/Representative is completed

UW Health

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

EXCHANGE OF INFORMATION Authorization for Release of Verbal Communication AND Exchange of Written Information

1. Patient Information

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

2. Exchange of Information between: ☐ UW Health (or):

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

3. And: (only one person/organization/phone # per authorization)

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

Information to be Disclosed: **BOTH** verbal and written information - if only one is exclusively being requested, use Authorization for Release of Medical Information 1280490-DT or Authorization for Verbal Communication 1280490V-DT.

4. ☒ **Written Medical Record Documentation to be Disclosed** (to be considered valid either line below must be completed):
Records pertaining to (Dates or Conditions): _____
Other (describe):_____

AND

5. ☒ **Exchange of Verbal Communication between those listed in Sections 2 & 3**

6. ☐ Additional option to leave **VOICE MAIL** to those listed in Section 3
Voice mail includes any information, unless specified: _____

7. Purpose or Need for Disclosure: Care Coordination unless otherwise specified:_____

8. This authorization will expire one year from signature unless otherwise indicated below:
☐ 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. 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 to the patient and authority to do so. (See reverse for more information)

Print Name: _____Relationship: _____

Patient is: ☐ Minor ☐ Incompetent / Incapacitated

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor
☐ Health Care Agent ☐ 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.

Verbal Communication. This authorization allows for verbal communication (both in person and on the telephone) between UW Health and the designated person(s) on this form (Sections 2 & 3). In addition, an option is provided to allow for UW Health to leave voice messages on a messaging system for the person(s) listed in Section 3. This is to provide more timely communication.

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 Health Care Privacy Laws: These laws protect the confidentiality of patient heath care records and they indicate when records may be disclosed without your 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 at the address listed above.

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 UW Health - Health Information Management (see address above).

Copy 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, or call (608) 263-6030, Option 3.