Patient Name:

DOB:

MR #:

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☐ Check this box if the authorization only needs to be scanned to the chart (Staff Only)

UW Health
(University of Wisconsin Hospitals and Clinics Authority)
(SwedishAmerican Hospital)
Access Community Health Centers

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form is not to be used for verbal communication. If requesting verbal communication, use Authorization for Verbal Communication and/or to Leave Voice Mail Messages form.

1. Patient Information

Name – Last, First, MI (Maiden or former name)			
Street Address	City	State	Zip Code
Medical Record Number (only if known)	Birth Date	Phone Number	

2. Release Information From (select all that apply)

☐ UW Health Hospitals and Clinics
☐ UW Health Rehab Hospital
☐ Generations Fertility Clinic
☐ Wisconsin Sleep
☐ Transformations
☐ UW Health SwedishAmerican Hospitals and Clinics
☐ Access Community Health Centers
☐ Madison Surgery Center
☐ Other Healthcare Organization (Complete Following Section)

Name: - (e.g., Health facility, physician name):

Address:

Phone Number:

Fax Number (if applicable):

3. The Information may be Released to: ** Please Provide Full Mailing Address of Recipient or Request May be Rejected **

Name - (e.g., Health Facility, Physician Name, Family Member):

Mail Address (include Apt/Suite#, if applicable):

City: State: Zip Code:

Phone Number:

Fax Number (if applicable): Email (if applicable):

4. Purpose or Need for Disclosure

☐ Further Medical Care ☐ Insurance Coverage ☐ Legal ☐ Disability determination
☐ Workers' Compensation ☐ Research ☐ Patient use ☐ Other: _____

5. Health Information to Be Released

Step 1 of 2

☐ Abstract Only *(includes Discharge Summary, History & Physical, Office Notes, Emergency Room Provider Notes, Operative/Procedure Reports, Pathology Reports, Consults, EKGs, Radiology Reports, Laboratory Reports)*
☐ Entire Medical Record (includes abstract, nursing notes, progress notes, physician orders, etc.)
☐ Billing Statement(s)/Claim(s): _____
☐ Substance Use Treatment Records from UW Health's Substance Use Treatment Programs as described here:
  ☐ All Substance Use Records
  ☐ Only records pertaining to the following: _____
☐ Records pertaining to (specify conditions or care team specialty): _____
☐ Other, please specify:_____

If you only want records marked above for a specific time period, please indicate here:
For records related to the following time period: _____ to _____

Imaging **(If images are needed select an option(s) below.)**
☐ Radiology ☐ Cardiology ☐ Surgery
☐ Eye/Ophthalmology ☐ Dental ☐ Other (specify): _____

Date(s) of selected medical images (if left blank, only the past two (2) years will be released):

From _____ To _____

Patient Name:

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Step 2 of 2 Optional Exclusion
This authorization includes the disclosure of information regarding substance use (referenced in general medical records), mental health*, developmental disabilities*, genetic testing, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results, unless I limit the disclosure to exclude the following: _____
***Witness signature required for IL patients on page 3**

6. Format for Record Delivery:

☐ Paper (mailed) ☐ Fax (List recipient fax number in Section #3) ☐ Patient's MyChart (Cannot Send to Proxy Accounts)
☐ Secure Portal. Internet access and valid email address required.
Email address for link to secure portal: _____
☐ Email (Please note that email is not a secure method of transmission)
Email address: _____
☐ EHI Extract (see page 3 for additional information). Extracts can only be delivered electronically. MyChart is the preferred method.
☐ Other: _____

Please note: If a format is not selected, records will be provided in paper format and will be mailed to recipient identified in #3 above.

*****Copies of medical images will be mailed on disk only.*****

7. Expiration Date: 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: ____/____/____

8. Authorization: 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 as specified in this Authorization.

Please read the following guidelines before signing this authorization.

Rights and Responsibilities: UW Health care providers honor a patient's right to confidentiality of protected health information as provided under federal and state law.

Release of Information: The information released may be obtained from the medical record of UW Health. 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.

Where to Send Authorizations, Revocation Requests, and other Medical Record Requests:

- **Authorizations for UW Health sites in Wisconsin** can be mailed to UW Health - Health Information Management, 8501 Excelsior Drive, Madison, WI 53717.
- **Authorizations for UW Health sites in Illinois** can be mailed to Health Information Management, UW Health SwedishAmerican Health System, 1401 East State Street, Rockford, Illinois, 61104.
- **Access Community Health Centers (Dental Image Requests only)** can be mailed to Access Community Health Centers, 2901 West Beltline Hwy. Suite 120, Madison, WI 53713. Request for medical and dental records can be sent to Access Community Health Centers, Health Information Management, 8501 Excelsior Drive, Madison, WI 53717.

You can also see a detailed listing of clinics that release their own records on uwhealth.org. This information is located in the Patient and Visitor section, How to Obtain Your Medical Records.

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. You can find a copy of the Notice of Privacy Practices on the website at uwhealth.org. This information is located on the bottom right corner of the website. Click on Notice of Privacy Practices (HIPAA).

Federal Substance Use Disorder Treatment Program Privacy (42 CFR Part 2): The federal confidentiality rules (42 CFR Part 2) that apply to substance use disorder treatment and/or referral records maintained by a Part 2 program prohibit any further disclosure of such records without the specific written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. However, a covered entity (or their business associate) to whom records are disclosed for purposes of treatment, payment, or health care operations, may redisclose such records in accordance with HIPAA (except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient). In addition, any other disclosures of information carry the potential for unauthorized re-disclosure and the information may not be protected by federal privacy standards.

General Designation for Disclosure of Substance Use Disorder Treatment Information: I understand I have made a general designation to disclose substance use disorder treatment and/or referral information to individuals or entities with which I have a treatment relationship. I may request a list of individuals or entities to which my substance use disorder information has been disclosed by contacting the appropriate location.

Patient Name:

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 healthcare 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 previous page 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.

For UW Health records, your revocation must be made in writing, signed by you or your legal representative, and delivered to the appropriate location.

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

Right to Inspect: You have the right to inspect or obtain a copy your records, with certain exceptions provided under state and federal law. If you would like to inspect your records, use the appropriate contact information provided above.

Fees: There is no charge for records requested by and released to other healthcare organizations. A fee may be charged for other requested purposes. See www.uwhealth.org for more details on fees assessed.

Multiple Formats for Release of Medical Records: You may request records to be provided to you in different formats; however, only one format will be released per authorization. You will be asked to submit a separate request for each format if multiple 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 this form to authorize the disclosure of your protected health 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.

EHI Extract: All EHI export files are required to include an accessible and up-to-date hyperlink that allows any user to directly access the EHI export file format information without preconditions or additional steps. The export file(s) created must be electronic and in a computable format.

EHI Extract file can only be delivered electronically. MyChart is the preferred method. Please note that due to technical settings in our EHR System, an EHI Export *may* include information from one or more of our affiliates and Community Connect partners: Agrace Hospice, Substance Use, Psych and HIV Clinics, Generations Fertility Clinic, Madison Surgery Center, UW Health Adolescent Alcohol/Drug Assessment and Intervention Clinic, Physicians for Women, Transformation Surgery Center, UW Rehab Hospital, Wisconsin Sleep, Quartz and Access Community Health Centers.

_____/_____/_____

Signature of Patient or Legal Representative | Relationship to Patient | Date

(Patients ages 12-17 may be required to sign and date with co-signature of parent/legal guardian)

_____ /_____/_____/_____

Co-Signature of Minor (If Applicable) | Print Name | Relationship to Patient | Date

_____ /_____/_____

Signature of Witness (If Applicable in Illinois)* | Print Name | Date