Patient Name:

DOB:

MR #:

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

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

Index to Auth – Communication

This does not authorize release of copies of medical records – Use form UWH1280490-DT
Authorization for Disclosure of Protected Health Information
Fax: (608) 662-4444

1. Patient Information:

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

2. Information to be Disclosed: Verbal communication only re: patient's care – This form is not to be used for production of medical records. If requesting written use Authorization for Disclosure of Protected Health Information (UWH1280490-DT).

3.

VERBAL COMMUNICATION BETWEEN:

☐ **All UW Health providers/locations or specify below**

Checking UW Health includes University Hospital, American Family Children's Hospital, UW East Madison Hospital, and UWH Urgent Care, Specialty Care, and Primary Care locations within Wisconsin.

OR

_____

(list name of UW Health healthcare facility or specific healthcare provider /staff member)

AND

First and Last Names and Phone Numbers (to whom your confidential information may be disclosed, **including yourself**)

	First/Last Name	**Phone Number**	**Leave voice mail for patient at this number?**	**Limit voice mail only to information specified:**
1.	_____ (Patient Name)	_____ (Patient Phone Number)	☐ Yes ☐ No	_____
2.	_____	_____	☐ Yes ☐ No	_____
3.	_____	_____	☐ Yes ☐ No	_____

4. Purpose of Communication: Continued care, unless specified: _____

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

☐ Until revoked in writing / indefinite

☐ Other specific expiration date: _____/_____/_____ (mm/dd/yyyy)
(If this authorization is for a minor and signed by a parent or legal guardian the expiration date cannot surpass their 18th birthday.)

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 substance use disorder, psychiatric consults and mental illness, 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: _____

Signature of Patient/Representative: _____ Today's Date: ____/____/____

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

Print Name: _____ Relationship: _____

Patient is:	☐ Minor	☐ Incompetent/Incapacitated	☐ Spouse/Domestic Partner of Deceased
Legal Authority:	☐ Legal Guardian ☐ Health Care Agent ☐ Personal Representative	☐ Parent of Minor	☐ Next of Kin ☐ Other: _____

ADDITIONAL INFORMATION REGARDING AUTHORIZATION FOR VERBAL COMMUNICATION AND/OR TO LEAVE VOICE MAIL MESSAGES

UW Health care providers honor a patient's right to confidentiality of protected health information as provided under federal and state law. Please read the following guidelines before signing this authorization.

"UW Health" includes the University Hospital, American Family Children's Hospital, UW East Madison Hospital, and UW Health Clinics. "UW Health" does **NOT** include joint ventures, including Access Community Health Center (ACHC), Agrace Hospice - HIM, 1102 S Park St Behavioral Health and Recovery clinic, Dr. Brown (AODA/HIV clinic), UW Health Care Direct, UW Health Fertility Care, Madison Surgery Center, Behavioral Health Youth and Family Clinic (Olin), UW Health Aesthetics and Plastic Surgery, UW Rehabilitation Hospital, and Wisconsin Sleep Clinic. If you wish to authorize communication with one of these locations, or a specific provider at one of these locations, please specify below.

Sending Authorizations to UW Health: Authorizations for UW Health sites can be faxed to (608) 662-4444 or 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 uwhealth.org. This information is located in the Patient & Family 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 left 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, any disclosure of information carries the potential for unauthorized re-disclosure and the information may not be protected by federal privacy standards.

Wisconsin Right to Privacy: Wisconsin law protects the confidentiality of patient healthcare records and indicates when records may be disclosed without your authorization.

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 UW Health – Health Information Management (Release of Information), 8501 Excelsior Drive, Madison, WI 53717, (608) 263-6030.

Verbal Communication Only: This authorization allows for verbal communication (both in person and on the telephone) between UW Health 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 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. If this authorization conflicts with a prior authorization the new one will revoke the old authorization. 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 mailed to: UW Health - Health Information Management (Release of Information), 8501 Excelsior Drive, Madison, WI 53717.

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.

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. 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.