

Index to Auth – Exchange Information

1. Patient Information

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

2. Exchange of Information between:

Access Community Health Centers (or):

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

3. And:

(Only one person/organization/phone number per authorization)

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

Information to be disclosed: **BOTH verbal and written information** - if only one is exclusively being requested, use *Authorization for Disclosure of Protected Health Information (ACHC302502-DT)* or *Authorization for Verbal Communication and/or to Leave Voice Mail Messages (ACHC302443-DT)*.

4. **Written Medical Record Documentation to be Disclosed:** Includes ANY and ALL records unless otherwise specified below:

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 (specify): ____/____/____

****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 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: _____ **Date:** ____/____/____

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

Print Name: _____ Relationship: _____

Patient is: Minor Incompetent/Incapacitated Spouse/Domestic Partner of Deceased

Legal Authority: Legal Guardian Parent of Minor Next of Kin

Health Care Agent Other: _____

Personal Representative

ADDITIONAL INFORMATION REGARDING AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Access Community Health Centers 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.

Release of Information: The information released may be obtained from the medical record of Access Community Health Centers. 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 Access Community Health Centers: Authorizations for Access Community Health Centers can be mailed to Access Community Health Centers, Attn: Release of Information/UW Health, 8501 Excelsior Drive, Madison, WI 53717 or returned to any Access clinic.

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 <https://accesscommunityhealthcenters.org/>.

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 Director of Risk Management and Safety, 2901 West Beltline Hwy, (608) 443-5545.

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, Access Community Health Centers 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 Access Community Health Centers records, your revocation must be made in writing and addressed to: Access Community Health Centers, Director of Risk Management and Safety, 2901 West Beltline Hwy, (608) 443-5545.

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 copy the protected health information for 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 department (for billing records) or Health Information Management department (for medical records) at 8501 Excelsior Drive, Madison, WI 53717 or (608) 263-6030, Option 3.

Fees: There is no charge for records requested by or released to other healthcare organizations. A fee will be charged for other requested purposes.

Multiple Formats for Release of Medical Records (Paper vs DVD): 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.

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: Director of Risk Management and Safety, 2901 West Beltline Hwy, (608) 443-5545.