Access COMMUNITY HEALTH CENTERS℠
Improving health. Improving lives.

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

This does not authorize release of copies of medical records – Use form ACHC1280490-DT Authorization for Disclosure of Protected Health Information
Fax: (608) 662-4444

Index to Auth-Communication

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 – **no copies of medical records provided**

3.

Verbal Communication Between:

_____ **and:** Name: _____
(list name of healthcare facility or specific healthcare provider/staff member. Listing "ACHC" will cover all ACHC 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 for the patient at the following phone number(s): _____

_____ (voice mail includes any information, unless limited below):

Limit voice mail only to information specified: _____
(see back of form for notice regarding voice mail messages)

AND/OR

Leave MESSAGE WITH AN INDIVIDUAL who answers the phone at the number provided in the box immediately 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:

☐ Give specific expiration date or write indefinite: _____

****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: _____ **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

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.

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

Voice Mail Messages: Access Community Health Center 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, 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.

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.