INSTRUCTIONS FOR COMPLETING AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

- NOTE that if an authorization is needed for disclosure of a patient's medical information for purposes of fundraising or marketing, a separate form is required, contact Development and Communications at (608) 443-5544.
- Item #2a Medical Records or Dental records to obtain: Description must be specific enough so that the patient can understand what information he or she is permitting to be disclosed. Thus, if "Other" section is used, description must be reasonably detailed (select one section per authorization). Select one box below for the records needed.
- Item #2b Substance Use Disorder (SUD) Records: Select all boxes that apply.
- Item #2c Format for record delivery: Select one box (paper, DVD or Other) for the format of records to be released. If this is left blank, records will be provided in paper format.
- Item #2d Medical Images to be disclosed from: Indicate the location where Medical images are from.
- Item #2e Specific Medical X-rays or Dental X-rays to be disclosed: Indicate if X-rays are needed or specific images relating to particular studies or dates.
- Item #3 Release Information FROM: Indicate the name of the organization to which records are to be released from (Select <u>one</u> per authorization) or write in the facility name and full address, phone and fax number.
- Item #4 Release Information TO: Indicate the specific person(s) or class(es) of persons outside the entity who will be permitted to receive the information with full mailing address, phone and fax number.
- Item #5 Purpose or need for disclosure - may be released electronically: Indicate any and all purposes for disclosure.
- Item #6 Expiration date: Enter specific expiration date if applicable.
- <u>Signatures</u>: In general, a patient age 18 or older is the only person with legal authority to sign this form. For patients younger than 18, generally the patient's parent or legal guardian must sign on behalf of the patient. There are many exceptions, however, to these general rules. For example:
    - If the patient has a guardian, the form may be signed by the patient's guardian or temporary guardian. If there is no guardian, and if two physicians have determined that the patient is incompetent, the form may be signed by the healthcare agent named in the patient's power of attorney.
    - If the patient is authorizing the use of HIV test results, he or she is permitted to sign this form regardless of age. If the patient is under the age of 14, a parent or guardian may sign on his or her behalf. If the patient is age 14 or older, a parent or guardian may not sign on his or her behalf.
    - If the patient is authorizing the use or disclosure of medical records involving treatment for mental illness, developmental disabilities, alcoholism or drug dependence, the patient is permitted to sign this form if he or she is age 12 or older. If the patient is between the ages of 12 and 18, a parent or guardian may sign on his or her behalf. If the patient is under the age of 12, a parent or guardian must sign.
    - For deceased patients, this form may be signed by the patient's surviving spouse or personal representative. If there is no surviving spouse or personal representative, immediate family members may sign. For this purpose, immediate family members are limited to adult children, parents, grandparents, and adult brothers and adult sisters of the deceased patient and their spouses.
    - All individuals signing for disclosure of medical information on behalf of a patient must state their relationship to the patient and may be required to provide proof of legal authority to permit the use or disclosure of the medical information.
- For information about signatures in other situations or answers to questions about these issues, please contact your supervisor or Director of Risk Management and Safety

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Access COMMUNITY HEALTH CENTERS℠

Improving health. Improving lives.

ACHC AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health Information Management
8501 Excelsior Drive
Madison, WI 53717
Fax: (608) 203-4580

Index to Auth-PHI

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	

2a. Medical Records to obtain (Select one) – for Medical Images/Films, see below under 2d and 2e	**2b. Substance Use Disorder (SUD) Records – will only be released if selected below (Please select all that apply)**
☐ Summary of Chart (includes consultations, outpatient notes, pathology reports, clinic summaries, X-ray (reports only), EKG and Lab reports for the most recent two years) ☐ Dental Records ☐ Records pertaining to (dates or conditions): _____ ☐ Other (describe):_____ ☐ Entire medical record from date ____/____/____to date ____/____/____	☐ SUD assessments ☐ Treatment notes and treatment plans ☐ Lab screening results ☐ Discharge Summary including SUD information ☐ All SUD information **from** date ____/____/____ **to** date ____/____/____ ☐ Other: _____

2c. Format for record delivery (Select one): ☐ Paper ☐ DVD (requires PDF viewer) ☐ Other format (specify): _____
Please note: If a format is not selected, records will be provided in paper format.

2d. MEDICAL IMAGES to be disclosed from (Select one): ☐ ACHC

2e. Specific MEDICAL IMAGES to be disclosed:
☐ Medical X-Rays ☐ Dental X-rays ☐ X-rays pertaining to: _____

3. Release Information FROM: (Select one)
☐ All Access Community Health Centers or Specify below:
☐ Other Healthcare Organization (Complete below)

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

4. Release Information TO: **Need full mailing address**

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

5. Purpose or need for disclosure - may be released electronically. (Select all applicable categories)
☐ Further medical care ☐ Payment of insurance claim ☐ Legal investigation ☐ Workers' compensation
☐ Application for insurance ☐ Vocational rehabilitation ☐ Patient use ☐ Research
☐ Disability determination ☐ Other: _____

6. 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: ____/____/____

****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

ACHC Release Documentation

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 and 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.