

Authorization for Verbal Communication and/or to Leave Voice Mail Messages

UNIVERSITY OF WI HOSPITAL AND CLINICS (UWHC)
UNIVERSITY OF WI MEDICAL FOUNDATION (UWMF)

This does not authorize release of copies of medical records –
Use UWH #1280490 or UWMF P-612-
Authorization for Release of Medical Information

1. Patient Information

Name – Last, First, MI		
Street Address		
City	State	Zip
Medical Record Number	Date of Birth	Phone Number

2. Information to be Disclosed: Verbal communication only – no copies of records provided

3. Communication Between UW Hospital & Clinics, UW Medical Foundation, **or** the employee/staff named below:

_____ **and:** Name: _____
(Name of specific health care provider/staff member)

Relationship: _____ Phone Number(s): _____

AND/OR

Leave Voice Mail at the Following Phone Number: _____
(See back of form for notice regarding voice mail messages)

May leave any type of message Limit types of voicemail to: _____

4. Purpose of Communication: Continued Care unless specified: _____

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

Indefinite Ends on (date) _____

****PLEASE SEE REVERSE FOR FURTHER INFORMATION****

In accordance with the conditions listed above and on the reverse side of this form, I authorize the use and/or disclosure of my medical information. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and/or HIV test results (if applicable) unless I limit the discussion to exclude the following medical conditions: _____

Signature of Patient _____ Date: _____

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

Relationship: _____

Patient is: Minor Incompetent / Incapacitated Deceased

Legal Authority: Legal Guardian Parent of Minor Spouse of Deceased

Health Care Agent _____

Personal Representative of Deceased Other _____

**ADDITIONAL INFORMATION REGARDING DISCLOSURE
OF PATIENT MEDICAL INFORMATION**

UW Health Care Providers (including the University of Wisconsin Hospital and Clinics (UWHC), the University of Wisconsin Medical Foundation (UWMF), and certain units of the University of Wisconsin – Madison) honor a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Sending Authorizations to UW Health: If mailing an authorization, please mail to the appropriate organization where you have received care:

University of WI Hospital and Clinics
Health Information Management
8501 Excelsior Drive
Madison, WI 53717

University of WI Medical Foundation
Health Information Services
7974 UW Health Court
Middleton, WI 53562

Verbal Communication Only. This authorization allows for verbal communication between UWHC or UWMF and the designated person on this form. It does not allow for copies of medical records to be released.

No Obligation to Sign. You are not under any 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 health care 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 reverse side 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. Your revocation must be made in writing and addressed to the appropriate originating organization:

- **UW Hospital and Clinics:** UWHC Health Information Management, 8501 Excelsior Drive, Madison, WI 53717 or fax number 608-203-4588
- **UW Medical Foundation:** UWMF Health Information Services – Release of Information Department, 7974 UW Health Court, Middleton, WI 53562

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical 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 a form to authorize the disclosure of your medical 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 form information regarding who is authorized to sign this form, contact the appropriate originating organization:

- **UW Hospital and Clinics:** UWHC Health Information Management at 608-263-6030, Option 3.
- **UW Medical Foundation:** UWMF Health Information Services – Release of Information Department at 608-826-6798

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.