Madison Women's Health LLP

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Information				
Name				Birth Date
Street Address	City	State	Zip Code	Best Phone

As the above named patient (or patient's legal representative), I authorize the release of medical records from the following health care facility:

Health Care Facility Name		
Street Address		
City	State	Zip Code

These records should be forwarded to: **Madison Women's Health, LLP**
5801 Research Park Boulevard, Suite 400
Madison WI 53719
FAX: (608) 729-1099

INFORMATION TO BE USED and/or DISCLOSED:

☐ All Medical Records ☐ Lab results ☐ Office Visits ☐ Immunization Records ☐ Allergy Records ☐ Other _____

For the following dates (if applicable): _____

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information please release records pertaining to: [Check all that apply]

☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol &/or Drug Abuse ☐ HIV test results ☐ Other (Specify): _____

For the Following Date(s): From_____ To_____.

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

☐ Transfer of Medical Care ☐ Specialty Consultation ☐ Disability Determination ☐ Visual Inspection of Records
☐ Personal ☐ Other (Specify)_____

EXPIRATION DATE: This authorization is good until (indicate date or event) _____(MM/DD/YYYY). If I do not specify a date, this authorization will remain in effect until this request is processed. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE: _____ **DATE:** _____

If this authorization is signed by a representative of the patient, please complete the following:

Representative's name: _____

The patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased
Your legal authority: ☐ Parent of minor ☐ Legal Guardian ☐ Power of Attorney ☐ Next of Kin

--PLEASE SEE REVERSE SIDE FOR IMPORTANT INFORMATION--

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization
I understand that if I sign this authorization, I have a right to receive a copy of this authorization.

Right to Refuse to Sign This Authorization
I understand that I am under no obligation to sign this form and that Madison Women's Health, LLP may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating protected health information (PHI) for disclosure to a third party.

Right to Withdraw This Authorization
I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the Privacy Officer listed below. I am aware that my withdrawal will not be effective until received by Madison Women's Health, LLP and will not be effective regarding the uses and/or disclosures of my health information that Madison Women's Health, LLP has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Right to Inspect or Copy the Health Information to Be Used or Disclosed
I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Officer listed below.

HIV Test Results
I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request

Redisclosure Notice
I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

Multiple Releases of Information
A patient may request multiple releases of information described on the authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's signature unless otherwise specified. A new authorization is necessary for release of information related to care provided after the date of the patient's signature, unless the authorization specifies release of future records of a specific test or a specific clinic appointment.

Who May Sign Authorization
Wisconsin Statutes recognize the need for informed consent. Generally, all patients 18 years of age and over must sign for release of their own medical records unless the following conditions apply:

- The patient is incompetent.
- The patient is disabled and cannot sign the form.
- The patient is deceased. (A surviving spouse or personal representative of the estate may sign. If no such person exists, then an adult member of the immediate family may sign).

Patients *less than 18 years of age* must sign for release of their medical records when:

- The patient is 14 years of age or older and the records involve mental health treatment or developmental disabilities (parents retain the right to access this information)
- The patient is 14 years of age or older and the records involve HIV test results
- The patient is 12 years of age or older and the records involve alcoholism or drug dependence
- The patient is an emancipated minor who is married or in the military
- The patient's records for release include abortion procedure.

All persons signing for release of protected health information on behalf of a patient must state their relationship to the patient and provide proof of their legal authority to act on behalf of the patient.

Privacy Officer: Bill Dickmeyer, 5801 Research Park Blvd, Suite 400, Madison WI 53719; (608) 729-6300