Associated Physicians
Devoted Physicians, Trusted Care.

4410 Regent St., Madison, WI 53705
Phone: 608-233-9746 Fax: 608-236-1981

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. _____ / _____
(Name of Patient) (Date of Birth)

_____ / _____
(Street Address) (City, State, Zip Code)

I authorize the use and/or release of my protected health information (PHI) as described below. I understand that this authorization is voluntary and is made to confirm my instructions. I also understand that the information used and/or released as a result of this authorization may no longer be protected by federal privacy laws and may be further used and/or released by persons or organizations receiving it without obtaining my authorization.

2. I AUTHORIZE:

_____
(Name of Physician/HealthCare Facility)

_____
(Street Address)

_____
(City, State, Zip Code)

3. TO RELEASE PHI TO:

_____
(Name of Physician/Health Care Facility/Other)

_____
(Street Address)

_____
(City, State, ZipCode)

_____
(Email address or clinic fax number)

4. PHI TO BE RELEASED:

Please describe the health information you would like released:

_____

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

☐ Continuing Care and Treatment (no patient signature required) ☐ Disability Determination ☐ Application for Insurance
☐ Specialty Consultation ☐ Vocational Rehab Evaluation ☐ Visual Inspection of Records ☐ Legal Investigation
☐ Personal
☐ Other:_____

6. EXPIRATION DATE:

This authorization will expire on ___ / ___ / ___ (MM/DD/YYYY). If I do not specify a date; this authorization will remain in effect for one year.

****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:_____

7. SIGNATURE:

I understand that by signing this form, I am confirming my authorization for the health care provider named in Section 2 to use and/or disclose the protected health information described above, to the persons and/or organizations named in Section 3. I understand written notification is necessary to cancel this request.

Signature of Patient or Legal Representative*:_____ **Date:** _____

**No signature is required if release is for continuing care and treatment*
**If this authorization is signed by a representative of the patient, please complete the following:*

Relationship:_____ Legal Authority: ☐ Legal Guardian ☐ Spouse of Deceased ☐ Health Care Agent ☐ Personal Representative ☐ Other: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

SEE REVERSE SIDE OF FORM FOR IMPORTANT INFORMATION ABOUT YOUR RIGHTS*

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ADDITIONAL INFORMATION REGARDING
THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Associated Physicians, LLP recognizes the patient's right to confidentiality of protected health information in accordance with the federal privacy rule and Wisconsin law. Patients should be aware of the following information when requesting the release of protected health information:

Right to Refuse to Sign this Authorization

A patient has the right to refuse to sign this authorization form and Associated Physicians, LLP will not condition treatment or payment of claims upon the provision that the patient signs this authorization form.

Right to Inspect or Copy the Information to be Used or Disclosed

A patient has the right to inspect or obtain a copy of the protected health information to be used or disclosed by signing this authorization form and may arrange a time to do so by contacting the medical records department.

Right to Receive a Copy of this Authorization

A patient has the right to request a copy of the signed authorization.

Right to Revoke Authorization

A patient has the right to revoke an authorization at any time by giving a written notice of revocation to the Privacy Officer listed below. Revocation of this authorization will not apply to information that has been released in compliance with this authorization *prior* to the receipt of the written notice of revocation. The revocation will not apply to the patient's insurance company when the law provides the insurer with the right to contest a claim under the patient's policy.

Redisclosure of Information by Recipient

Any disclosure of protected health information carries with it the potential for an unauthorized redisclosure. If the person(s) and/or organization listed in Section 3 are not health care providers, health plans or health care clearinghouses subject to the federal privacy rule, the protected health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and may be redisclosed without obtaining my authorization.

Multiple Releases of Information

A patient may request multiple releases of information described on the authorization form (Section 6). 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.

Marketing

If Associated Physicians, LLP uses this authorization for marketing activities, the patient will be informed if Associated Physicians, LLP receives any direct or indirect payment in connection with the use or disclosure of the patient's information.

HIV Test Results

A patient's 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.

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 (Section 7).

Privacy Officer:

Associated Physicians, LLP
Terri Carufel-Wert
4410 Regent Street
Madison, WI 53705
608-233-9746
Fax (608)233-0026

NOTE TO RECIPIENT OF INFORMATION: This protected health information has been disclosed according to federal and state privacy rules. Unless you have further authorization, these rules may prohibit you from redisclosing this information without the specific written consent of the patient or the patient's legal represent.