ASSOCIATED PHYSICIANS, LLP
DISCLOSURE AUTHORIZATION FORM

This form is used to confirm a patient's authorization for Associated Physicians, LLP to discuss or disclose his/her protected health information to the person or persons listed on this form. Use of patient information is strictly limited to the purposes described herein.

Section A: Patient Information

By signing this form in Section E below, I understand and agree that Associated Physicians, LLP may release my personal health information for the purposes defined in Section B below to the individual(s) named in Section C below.

Patient Name: ____

Address: ____

Telephone Number: ____

E-mail Address: ____

Section B: Type of Information to be Shared

I understand that I have the right to limit the information that Associated Physicians, LLP releases under this authorization. For example, I may limit access to information from a particular health care provider or to a particular record. Any such limitations must be described below in writing. **Please check the line next to each category of information you are consenting to share.**

___ Billing, insurance, and collections information

___ Healthcare treatment and records

___ Lab and other test results

___ Other: ____

Specific Authorization for Mental Health, Substance Abuse Treatment or AIDS-Related Information:
I authorize the release and disclosure of any and all personal health information, including mental health information, substance abuse (drug or alcohol), and AIDS or HIV-related information, if applicable, and all claims information to the individual named below as long as this authorization is in effect. I understand that I may inspect the mental health information disclosed.

Initials: _______

Section C: Authorized Use and/or Disclosure

Intended Use or Disclosure:

I understand that it is the policy of Associated Physicians to not disclose a patient's personal health information to other parties without the patient's authorization, except when permitted or required by law. For this reason, I authorize Associated Physicians to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with or facilitating my healthcare or health plan benefits. I also understand that if the individual(s) named below is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and may be subject to further disclosure without my authorization. I acknowledge that my authorization is voluntary, and that signing this authorization is not required in order to receive treatment or be eligible for benefits.

Recipient #1:

Name: ____

Phone Number: ____

Address: ____

Relationship to You: ____

Recipient #2:

Name: ____

Phone Number: ____

Address: ____

Relationship to You: ____

Section D: Expiration and Revocation

This authorization will automatically expire after the time frame I designate below by initialing. I understand that I have the right to revoke or end this authorization at any time. I understand that if I do not wish the person(s) named in Section C to receive my personal health information, I must revoke this authorization **in writing** by giving written notice of my decision to the contact person named below or completing revocation below. I understand that my revocation of this authorization will not affect any action that Associated Physicians has already taken, or any information that Associated Physicians has already released, based upon this authorization before receipt of my request to revoke it.

One Year: _____ No Expiration: _____ Other: ________

I revoke previous authorization form: ☐ Yes or ☐ No | Comments:____________________________________

Contact:
Privacy Officer
Associated Physicians, LLP
4410 Regent Street
Madison, WI 53705

Section E: Signature / Authorization

I have had full opportunity to read and consider the content of this authorization. I confirm that this authorization is consistent with my request of Associated Physicians, LLP. I understand that, by signing this form, I am confirming my authorization that Associated Physicians, LLP may use and/or disclose my personal health information to the person(s) named in Section C for the purpose described above.

Signature and Date

Please return the signed authorization form to the clinical reception desk or contact person listed in Section D. You are entitled to a copy of this authorization form after you sign it.

____ ____________________
Signature of Patient Date

____ ____________________
Signature of Personal Representative Date

____
Relationship to Patient