Children's Wisconsin

Authorization for General Disclosure of Patient Health Information

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____ Telephone Number: _____

INFORMATION TO BE DISCLOSED BY:

☑ Children's Wisconsin ☐ Children's Community Services ☐ Children's Medical Group

☐ Other: _____

INFORMATION GIVEN TO/SHARED WITH:

Name: Coaches, other (current and past) participants, individuals who have been diagnosed and treated for cancer/BMT, and their families and volunteers of the triathlon training program.

Street Address: _____

City: _____ State: _____ Zip Code: _____

REASON INFORMATION BEING SHARED:

1. The reason we are sharing the personal health information is to allow the named patient to participate in Children's WI triathlon training program.
2. To identify to the coaches and volunteers for the "Children's WI Cancer Survivor Triathlon Training Program" past or current cancer patients who have registered to participate in this program.
3. To encourage other past or current cancer patients to participate in the "Children's WI Cancer Survivor Triathlon Training Program".

INFORMATION TO BE SHARED:

Personal information (image, diagnosis of cancer or BMT and name) may be disclosed during participation:
1. Names of past or current cancer patients who have registered to participate in the "Children's WI Cancer Survivor Triathlon Training Program".
2. Photos of past participants in the "Children's WI Cancer Survivor Triathlon Training Program" to help promote program for future years.

EXPIRATION DATE: This Authorization is valid until the following date/event: (not to exceed 3 years) 12/31/2026
If no date is listed, this authorization is good for three (3) years from the date signed below.

SIGNATURE

I have read, understand and agree to the information above and on the back of this form. I am legally able to authorize the sharing of my/the child's patient health information, and by signing below I hereby give my authorization.

_____ _____

Patient, Parent or Legal Representative Signature Date

_____

Relationship to Child

PLEASE READ THE FOLLOWING BEFORE VOLUNTARILY SIGNING THE FRONT OF THIS DISCLOSURE FORM

NOTICE OF PRIVACY PRACTICES: You have been given a copy of the Children's Hospital of Wisconsin Notice of Privacy Practices which describes the rights of Children's Hospital of Wisconsin and yourself to disclose patient information.

SUBSEQUENT RELEASE: You are aware that the patient information may potentially be re-disclosed by the recipient and may no longer be protected by United States of State confidentiality laws.

RIGHT TO REFUSE TO SIGN: You understand that this authorization is voluntary and that you may refuse to sign it, in which case Children's Hospital of Wisconsin will not release the patient information specified in this form. Your decision to not sign the authorization will not affect your child's ability to receive any viable treatments available to your child.

REVOCATION: You understand that you have the right to revoke this authorization at anytime. Your revocation must be sent in writing to the Director, Health Information Management, P.O. Box 1997, Milwaukee, WI 53201. Your revocation will not apply to any patient information already released in response to this, or any other, authorization.

LIABILITY: All members of the workforce of Children's Hospital of Wisconsin, as described in the Children's Hospital of Wisconsin Notice of Privacy Practices, are released from any and all legal responsibilities for the release of information as specified in this form.

COPY: You will be provided a copy of this form after you sign it and it is accepted by Children's Hospital of Wisconsin.