Children's Hospital of Wisconsin

Authorization for the Use or Disclosure of Patient Health Information

Wisconsin HIV Primary Care Support Network

Medical Record Number: _____

Visit Number: _____

1. PATIENT INFORMATION:

Last Name | MI | First | Date of Birth

Address | City | State | Zip

Cell Phone | Home Phone | Email

2. I GIVE PERMISSION FOR THESE ENTITIES TO EXCHANGE INFORMATION BETWEEN THEM

☐ **All of the listed Programs / Agencies / Institutions**

- ☐ Medical College of Wisconsin - (Network lead agency)
- ☐ AIDS Resource Center of Wisconsin
- ☐ Children's Hospital of Wisconsin
- ☐ Milwaukee Health Services, Inc.
- ☐ Marshfield Clinic`
- ☐ City of Milwaukee Health Department
- ☐ ACL Laboratories
- ☐ Outreach Community Health Centers
- ☐ UW Health
- ☐ Dynacare Laboratories
- ☐ Mayo Clinic
- ☐ Mayo Clinic Health System

3. VERBAL EXCHANGE OF INFORMATION ☐ CHECK THIS BOX TO ALLOW VERBAL COMMUNICATIONS AMONG THOSE INDICATED ABOVE

- **NOTE - If only allowing verbal communication and NO medical records should be sent, skip to number 7**

4. MEDICAL RECORD INFORMATION TO BE RELEASED: (See back for important tips):

☐ Entire Record

☐ Clinic Records (specify): _____

☐ Inpatient Hospital Records from dates of service: From: _____ To: _____

☐ Only these specified documents: _____

☐ Consults ☐ Discharge Summary ☐ Diagnostic ☐ ER Visit ☐ History and Physical ☐ Lab

☐ Operative Report ☐ Pathology Report ☐ Radiology Report ☐ Other: _____

☐ Radiology Films: _____

☐ Other: _____

5. I DO NOT WANT THE FOLLOWING INFORMATION RELEASED OR DISCUSSED: (as defined by applicable state and federal laws)

☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV Test Results ☐ Genetics

☐ Alcohol/Drug Treatment ☐ Other (Please List): _____

6. HOW INFORMATION WILL BE RELEASED:

Check all that apply: ☐ Verbal ☐ Paper ☐ MyChart

- **IF PAPER OR ELECTRONIC, RELEASED BY:** ☐ **MEDICAL RECORDS** ☐ **OTHER (specify):** _____

Release By: ☐ US Mail ☐ Pick Up ☐ Fax (only to healthcare organizations): _____

Person allowed to pick up records if other then the person listed above in Number 3

Name | Relationship

7. PURPOSE OF THE DISCLOSURE: ☐ Continuation of Medical Care

8. EXPIRATION DATE:

This Authorization is valid until the following date/event: (not to exceed 3 years): _____

If no date is listed, this authorization is good for three (3) years from the date signed below.

This includes records that are created after the date this authorization is signed, up until the expiration date.

9. PLEASE SEE BACK SIDE OF THIS FORM BEFORE SIGNING FOR MORE INFORMATION.

I have read, understand and agree to the information above and on the back of this form, I authorize the release of my/the child's Patient Health Information.

Patient, Parent or Legal Guardian Signature | Date

☐ Parent - I declare that I am the above named minor child's guardian.

☐ Self ☐ Legal Guardian (must provide paperwork) ☐ Other (please list): _____

10. STAFF: _____ Date: _____

Please see back side of this form to find out when a witness is needed to sign the form.

THINGS THAT CLIENTS SHOULD KNOW ABOUT THE WISCONSIN HIV PRIMARY CARE SUPPORT NETWORK BEFORE THEY SIGN THE "AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION"

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

All of the Wisconsin HIV Primary Care Support Network, **its partners or agencies**, herein referred to as the Network, respect the patient's right to privacy and confidentiality and each staff member is committed to maintaining the client's privacy and confidentiality as required by the employing agency. I have had an opportunity to review and understand the content of both sides of this Disclosure form. If I have any questions or need further information, I will contact the Wisconsin HIV Primary Care Support Network at414-337-7077 or direct my questions in writing to: Children's Hospital of Wisconsin, WI, HIV Primary Care Support Network Pediatric Infectious Diseases, Suite C450, PO Box 1997, Milwaukee, WI 53201.

PROHIBITION OF RE-DISCLOSURE. Federal and Wisconsin Confidentiality laws protect this information. Such laws prohibit the re-disclosure of such information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by such laws.

RE-RELEASE I understand that the information disclosed may potentially be re-disclosed by the recipient and may no longer be protected by the Federal Privacy and Confidentiality rules.

NETWORK AGENCIES Before signing, the client should have met with at least one staff member of the following collaborating agencies.

- **Medical College of Wisconsin - (Network lead agency)**
- **AIDS Resource Center of Wisconsin**
- **Children's Hospital of Wisconsin**
- **Mayo Clinic**
- **Milwaukee Health Services, Inc**
- **City of Milwaukee Health Department**
- **ACL Laboratories**
- **Outreach Community Health Centers**
- **Mayo Clinic Health System**
- **Marshfield Clinic**
- **UW Health**
- **Dynacare Laboratories**

RIGHT TO REFUSE TO SIGN I understand that this authorization is voluntary and that I may refuse to sign it. The Wisconsin HIV Primary Care Network will not condition my treatment, payment, enrollment in a health care plan or eligibility for health care benefits based on my decision to sign this Disclosure. I understand that if I voluntarily refuse to sign this form, the information may not be released.

REVOCATION I understand that I have the right to revoke this authorization at anytime. I must do so in writing to the Wisconsin HIV Primary Care Network. My revocation will not apply to confidential information that has already been released in response to this or another Disclosure form.

LIABILITY All Wisconsin HIV Primary Care Network entities, employees, officers and attending physicians are released from legal responsibility or liability for the release of information as indicated on this form.

NETWORK SERVICES The Network provides services to infants, children, youth and women with HIV infection and their families. The staff members of the Network's agencies work closely together with client's health care and social service providers.

ELECTRONIC HEALTH RECORD The Network uses an electronic health record to summarize medical, social service and other health care information about each client's health care and other circumstances including information about the HIV status of each client.

SERVICE DELIVERY In order for the Network's agency staff members to effectively provide services to the client, all care providers need to have access to information about the client. This information includes all of the client's health care records, including information related to the client's HIV status and all of the services that the client receives. This information may be included in the Network's electronic health record described above.

CONSULTATION OF SERVICES The agencies of the Network believe that the best interests of the client are served if the staff members of the Network's agencies are able to share information about the client in individual and/or group consultations. These consultations involve discussion of the client's physical and/or mental health (including the client's HIV status), social services, private/governmental assistance programs, and/or other community-based services which may be deemed beneficial to the client.

VALIDITY OF FORMS A photocopy or facsimile (fax) of this Disclosure Form is as valid as the original.

******AN ABSTRACT MAY INCLUDE** - Discharge Summary, History & Physical, Consultations, Operative Reports, Lab Reports, Radiology Reports, Emergency Reports and Computer Database.

WHEN A WITNESS IS NEEDED

A witness is required to sign this form in the following circumstances: when the client or parent/legal guardian is unable to sign or only make a mark; when a minor legally accesses information or in other circumstances determined to require a witness.