University of Wisconsin
Medical Foundation

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

1. Patient Identification.

Name – Last, First, MI		
Address Street Address		
City	State	Zip Code
Record Number (brown card)	Birth Date	Phone No.

2. Information to be disclosed. ***(Please check only one box.)***

- ☐ Comprehensive overview of entire chart (contains all Discharge Summaries; all Outpatient Notes; all Pathology Reports; and all Clinic Summaries, x-ray, EKG and Lab Reports)
- ☐ Records Pertaining to: ______________________ date(s) or condition(s)
- ☐ Complete Copy of Official Medical Record
- ☐ Other (describe): ______________________

3. Disclosed By:

Name (e.g. Health Facility, Physician ...)		
Address		
City	State	Zip Code

4. Disclosed To:

ExamOne
800 NW Chipman Rd. / Suite 5900
POBox 2340
Lee's Summit, MO 64063-1149

5. Purpose or need for disclosure. ***(Please check all applicable categories.)***

☐ further medical care	☐ payment of insurance claim	☐ legal investigation
☐ application for Insurance	☐ vocational rehabilitation	☐ patient use
☐ disability determination	☐ transfer care to another physician	☐ other (describe):

6. This authorization will remain in effect until the above disclosure(s) have been completed unless you specify that this authorization will be effective for an additional time period. ***(To specify an additional time period, please check <u>one</u> of the boxes below. NOTE that if you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.)***

- ☐ Other specific expiration date: ______________ (mm/dd/yyyy)
- ☐ Other expiration event (specify): ______________________

*****PLEASE SEE REVERSE FOR FURTHER INFORMATION*****

In accordance with the conditions listed above and on the reverse side of this form, I authorize the use and/or disclosure of my medical information. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and/or HIV test results, with the following exception(s):

Exception(s): ______________________

______________________ ______________
Signature of Patient **Date**

If signed by person other than patient, state relationship and authority to do so. (See reverse for information about signatures.)

Relationship: ______________________

Patient Is: ☐ Minor ☐ Incompetent/ Incapacitated ☐ Deceased

Legal Authority:
- ☐ Guardian of the Person ☐ Parent of Minor ☐ Spouse of Deceased
- ☐ Health care agent
- ☐ Personal Representative of Deceased
- ☐ Other: ______________________

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

UW Health Care Providers (including the University of Wisconsin Hospitals and Clinics, the University of Wisconsin Medical Foundation, and certain units of the University of Wisconsin-Madison) honor a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, UW Health Care Providers may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to the Director of Health Information, Medical Records Department, 1 South Park Street, Madison, WI 53715.

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the Director of Health Information at (608) 287-2333 for further information.

Copying Fees. If you are requesting disclosure/release of medical information to other hospitals, clinics, or physicians for further medical care, no copying fees will be charged. You must pay for copies you request for other reasons.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, please contact the Patient & Family Relations Department at (608) 265-0400.