Office of Compliance
UNIVERSITY OF WISCONSIN-MADISON

Authorization for Disclosure of Medical Information for Publication or Conference Presentation

1. Patient/Subject Identification.

Name – Last, First, MI		
Street Address		
City	State	Zip Code
Birthdate	Phone Number	

2. Information to be disclosed. *(Please check all applicable categories.)*

- ☐ Full face photographs
- ☐ Unique or unusual diagnostic or treatment information that may be identifiable (describe): _____
- ☐ Other (describe): _____

3. Used/Disclosed By:

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

4. Disclosed To:

Attendees at conference as described below in 5. -OR-
Readers of journal as described below in 5.

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

- ☐ Conference presentation, as follows:
  - Title of presentation: _____
  - Conference name, date, and location: _____
- ☐ Publication in a journal article, as follows:
  - Title of article: _____
  - Title and number/volume of journal: _____
- ☐ 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 for a conference presentation or journal article as stated above. I understand that the images and/or information may be seen or read by members of the general public in addition to physicians, medical researchers and scientists who usually attend such conferences or read such journals.

Signature of Patient/Subject: _____ **Date:** _____

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

Name and Relationship: _____

Patient/Subject Is: ☐ Minor ☐ Incompetent/ Incapacitated ☐ Deceased

Legal Authority:
- ☐ Guardian
- ☐ Health Care Agent
- ☐ Parent of Minor
- ☐ Personal Representative of Deceased
- ☐ Spouse of Deceased
- ☐ Other: _____

Additional Information Regarding Disclosure of Medical Information

UW-Madison health care providers honor individuals' rights to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Federal HIPAA Privacy Rules: These federal rules indicate when your protected health information may be used or disclosed without your authorization. Please see our Notice of Privacy Practices for additional information.

Wisconsin Right to Privacy: Under Wisconsin law, you have the right to be free from unreasonable invasions of privacy. Wisconsin's "Right of Privacy" statute prevents individuals from using your name, portrait, or picture for advertising or trade purposes without first obtaining your written 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-Madison 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 already made by the person(s) and/or organization(s) listed on the reverse side of this form, in reliance on this authorization, before the time of your revocation. Your revocation must be made in writing and addressed to the UW-Madison HIPAA Privacy Officer (contact information below in "Signatures" section).

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, the disclosure of which you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your medical information, contact the UW-Madison HIPAA Privacy Officer for further information (contact information below in "Signatures" section).

Signatures. Generally, if you are 18 years of age or older, you are the only person 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 situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact the UW-Madison HIPAA Privacy Officer:

UW-Madison HIPAA Privacy Officer
361 Bascom Hall, 500 Lincoln Drive
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hipaa@wisc.edu
www.compliance.wisc.edu/hipaa

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