Staff Instructions for Completing Authorization for Disclosure of Medical Information

UW-Madison staff obtaining or receiving authorization need to review these instructions in full before using or accepting the attached authorization form.

Patients/participants should not be provided with these instructions.

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1. The authorization form needs to be filled out completely and accurately to be valid
    a. Fields 1-6 on the UW-Madison Authorization for Disclosure form(s) need to be completed by staff before being given to the patient/participant for signature
    b. In cases where the authorization is requested and filled out by the patient/participant, staff should review to ensure all fields are filled out completely and accurately

2. The authorization form should be written broadly enough to enable all anticipated use cases of the information to be released
    a. If the patient/participant wishes to modify any fields, staff should discuss and ensure modifications still facilitate anticipated use cases
    b. In cases where the authorization is requested by and filled out by the patient/participant, staff should review to ensure the form accurately reflects the individual's stated intent

3. If the authorization will be signed by someone other than the patient (for an adult) or a parent (for a minor), please contact your Privacy Coordinator before disclosing information under this authorization to confirm that it is appropriate for this individual. This includes situations in which a minor is attempting to sign authorization on their own behalf

4. Staff must give the patient/participant a copy of the signed authorization

5. Staff should also save a copy of the signed Authorization and store it securely in accordance with departmental policy
    a. Contact your Privacy Coordinator with any questions about departmental policy

Office of Compliance
UNIVERSITY OF WISCONSIN–MADISON

Authorization for Disclosure of Medical Information for Publication or Presentation

1. Individual/Patient/Participant Identification:

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

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

☐ The following identifying photograph(s) or video(s): _____
☐ The following unique or uncommon diagnosis, condition, or treatment: _____
☐ Other identifying information (describe): _____

3. Used/Disclosed By:

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

4. Disclosed To:

See details in 5. below

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

☐ Presentation information, as follows:
Title of presentation: _____
Event name, date, and location: _____
☐ Publication, as follows:
Title of article: _____
Title of publication: _____
☐ Other (describe where information will be shared): _____

6. Expiration and optional extension:

This authorization stays in effect until the disclosures of the information listed in Section 2 have been completed, unless you specify an extended time period by selecting ONE of the boxes below. If you choose to extend the time period, this authorization will cover new information created during the extended time period when the information is the same as described in Section 2.

☐ Other specific expiration date (mm/dd/yyyy): _____

☐ Other expiration event (specify): _____

BEFORE SIGNING PLEASE SEE REVERSE FOR ADDITIONAL INFORMATION ON YOUR RIGHTS

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 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 presentations or read such publications.**

Signature of Individual/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: _____

Individual Is: ☐ Minor ☐ Incompetent/ Incapacitated ☐ Deceased

Legal Authority: ☐ Guardian ☐ Parent of Minor ☐ Spouse of Deceased
☐ Active Health Care Power of Attorney ☐ Personal Representative of Deceased
☐ Other: _____

Additional Information About Your Rights

There are federal and state laws that protect your medical information. Before signing, please read the following to ensure you understand how these laws and regulations apply to this authorization and your medical information.

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 at any time before it ends. However, if you revoke this authorization, it will not change or undo any sharing of your medical information that already happened before your revocation. Any person or organization listed on this form may still use information they already received. Your revocation must be made in writing and submitted using the contact information at the end of this form.

Re-release. HIPAA only applies to certain types of entities. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not subject to HIPAA, then that information may no longer be protected by HIPAA. Once shared, that person or organization may be able to further share your information without your permission.

Signatures. Generally, if you are 18 years of age or older, you are the only person permitted to sign this form. If you are under the age of 18, in most circumstances your parent or guardian must sign this form for you. However, there are situations in which these general rules do not apply. For more information on these exceptional situations, contact the UW-Madison HIPAA Privacy Officer (contact information below).

Additional Rights Under HIPAA. HIPAA also provides additional rights that don't just apply to this authorization. If you would like additional information on these other rights, you can review the Notice of Privacy Practices that you were provided by your clinic or contact the Privacy Officer with the contact information below.

UW-Madison HIPAA Privacy Officer
361 Bascom Hall, 500 Lincoln Drive
Madison, WI 53706
hipaa@wisc.edu
www.compliance.wisc.edu/hipaa

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