UW Health

Index to Auth – Exchange Information

AUTHORIZATION FOR RELEASE OF VERBAL COMMUNICATION AND EXCHANGE OF WRITTEN INFORMATION

Health Information Management
8501 Excelsior Drive
Madison, WI 53717
Fax: (608) 662-4444

1. Patient Information

Name – Last, First, MI (Maiden or former name)			
Street Address	City	State	Zip Code
Medical Record Number (only if known)	Birthdate	Phone Number	

2. Exchange of Information between: ☒ UW Health (or):

Name – (e.g. Health Facility, Physician…)		
Address		
City	State	Zip Code
Phone Number	Fax	

3. And: (Only one person/organization/phone# per authorization)

Name – (e.g. Insurance Company, Lawyer, Physician, Patient)		
Address		
City	State	Zip Code
Phone Number	Fax	

Information to be disclosed: **BOTH verbal and written information** - if only one is exclusively being requested, use *Authorization for Disclosure of Protected Health Information (UWH1280490-DT) or Authorization for Verbal Communication and/or to Leave Voice Mail Messages (UWH302443-DT).*

4. ☒ **Written Medical Record Documentation to be Disclosed**: Includes ANY and ALL records unless otherwise specified below:
Records pertaining to (dates or conditions): _____
Other (describe): _____

AND

5. ☒ **Exchange of Verbal Communication between those listed in Sections 2 & 3**

6. ☐ Additional option to leave **VOICE MAIL** to those listed in Section 3
Voice mail includes any information unless specified: _____

7. **Purpose or need for disclosure:** Care Coordination unless otherwise specified: _____

8. **This authorization will expire** one year from signature unless otherwise indicated below:
☐ Other specific expiration date (specify): ____/____/____

****PLEASE SEE NEXT PAGE FOR FURTHER INFORMATION****

In accordance with the conditions listed above and on the next page of this form, I authorize the use and/or disclosure of my medical information. I understand that there may be a charge for copies. This authorization includes disclosure of information regarding substance use disorder, psychiatric consults and mental illness, developmental disabilities, genetic testing, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results, unless I limit the disclosure to exclude the following: _____

_____

Signature of Patient/Representative: _____ **Date:** ____/____/____

If signed by person other than the patient, print name and state relationship and authority to do so. (See next page for information about signatures)

Print Name: _____ Relationship: _____

Patient is:	☐ Minor	☐ Incompetent/Incapacitated	☐ Spouse/Domestic Partner of Deceased
Legal Authority:	☐ Legal Guardian	☐ Parent of Minor	☐ Next of Kin
	☐ Health Care Agent		☐ Other: _____
	☐ Personal Representative		

Tips for Use of Authorization for Release of Verbal Communication AND Exchange of Written Information

PURPOSE: To ensure authorization is on file for current and future sharing of information between those listed in Sections 2 and 3 only
Examples for use (but not limited to):

- School issues (ADD, IEP, asthma or other chronic conditions) communicated with and released to school staff
- Working with payers to certify/pre-approve services
- Coordination of community/social services (excluded from continuity of care purposes which doesn't require an authorization)
- Coordination of medical services where special authorization is required: Mental Health, Substance Use Disorder, HIV test results where both verbal AND written authorization is needed

Examples **NOT** for use:

- NOT INTENDED FOR HIM (Health Information Management) TO IMMEDIATELY RELEASE COPIES – ONLY THE PERSON LISTED IN SECTIONS 2 AND 3 MAY SHARE
- Provider to provider exchange of PHI (does not require authorization)
- For the sole purpose of releasing copies of PHI
  - Use form UWH1280490-DT Authorization for Disclosure of Protected Health Information
- For the sole purpose of authorizing verbal communication
  - Use form UWH302443-DT Authorization for Verbal Communication and/or to Leave Voice Mail Messages

Form Completion Tips:
Section 1 – Use label with MRN and DOB, if not already pre-populated when printing from Cadence
Section 2 – Check either UW Health or a particular clinic/unit or specific person authorized to exchange information

- Least Restrictive: Organization
- Moderately Restrictive: Smaller section within an organization
- Most Restrictive: List an individual person (limits the exchange for that person only)

Section 3 – Enter name of organization/person authorized to receive/exchange information with that listed in Section 2

- Least Restrictive: Organization
- Moderately Restrictive: Smaller section within an organization
- Most Restrictive: Individual person (including first and last name)
- Full address should be included to allow for exchange of PHI
- Phone number is only required when authorized to communicate via telephone and/or leave voice mail messages
- **NOTE**: Only one person/organization may be listed per authorization. If multiple people/organizations are desired, an authorization is required for each one, except for mother/father from same household

Sections 4 and 5 – Include what type(s) of information can be shared, if different from ANY AND ALL – These boxes are pre-checked as both situations must apply in order to use this authorization

- Section 4 – **(Must Be Completed)** Written: Can be defined by condition/diagnosis (asthma, ADD, lung cancer), date range (past 5 years), or other (specific forms/tests/procedures, etc.)
- Section 5 – Verbal: Two-way communication

Section 6 – Additional options for voice mail – Check box if patient authorizes voice mail messages to be left at the number listed in Section 3

- If patient authorizes leaving detailed voice mail on the patient's own voice mail, the Authorization for Verbal Communication and/or to Leave Voice Mail Messages (UWH302443-DT) should be used instead of this form
- Authorization includes any information to be left on voice mail, unless patient specifies on the authorization such limitations (example: no lab results, no OB appointment information, etc.)

Section 7 – Purpose of disclosure – Care Coordination is prepopulated as a default. If other reason, please enter
Section 8 – Authorization expiration – Standard expiration date will be one year from date of signature unless a new date is entered – if a longer period of time is requested by the patient, a five-year range is a good timeframe to use

- **NEW**: The option of Indefinite has been removed in order to reduce the risk of unknown authorization over a long period of time (patient forgets about an indefinite authorization)

Authorization paragraph:
This authorization includes disclosure of information regarding **substance use disorder, psychiatric consults and mental illness, developmental disabilities, genetic testing, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results,** unless the patient chooses to limit the information authorized.

- To do that, they must list the limitations in the space provided

Signature of Patient/Representative: Signed by person legally authorized to sign
Signature of Guardian – Guardianship is a legally authorized designation – see FYI flag and scanned document for appropriate legal papers

- Stepparent cannot sign unless legal papers are on file

Date – Enter the date in which the patient/representative/guardian signed the authorization
Patient is/Legal Authority – Complete if Guardian/Representative is completed