WAISMAN CENTER
COMMUNICATION DEVELOPMENT PROGRAM (CDP)
University of Wisconsin-Madison
1500 Highland Avenue–Room 322
Madison, WI 53705-2280
Office/TDD: 608.262.3039
FAX: 608.265.9851
cdp@waisman.wisc.edu

EXCHANGE OF INFORMATION

Authorization for Release of Verbal Communication AND Exchange of Written Information

1. Patient Information

Name- Last, First, MI	Date of Birth	County ID Number (if known)	
Street Address	City	State	Zip

2. Exchange of Information between:

Name – (e.g. Health Facility, Physician…)		
Communication Development Program (CDP)		
Address		
1500 Highland Ave., Rm. 322		
City	State	Zip Code
Madison	WI	53705

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

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

Information to be Disclosed: **BOTH** verbal and written information - if only one is exclusively being requested, use Authorization for Release of Medical Information 1280490-DT or Authorization for Verbal Communication 1280490V-DT.

4. ☒ **Written Records & Documentation to be Disclosed** (to be considered valid either line below must be completed):

Records pertaining to (Dates or Conditions): Medical Diagnoses, Developmental Information, Communication Skills/Needs

Other (describe): IEP, IFSP, Plans of Care

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 or event (specify): 18th Birthday (mm/dd/yyyy)

****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. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, 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:** _____(mm/dd/yyyy)

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

Print Name: _____ Relationship: _____

Patient is: ☒ Minor ☐ Incompetent / Incapacitated

Legal Authority: ☐ Legal Guardian ☒ Parent of Minor
☐ Health Care Agent ☐ Other _____

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Waisman Center Communication Development Program (CDP) Providers honor a client's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Release of Information: The information released may be obtained from the client's records in the Communication Development Program (CDP) and the designated person(s) or organization(s) on this form (Sections 2 & 3). It may be obtained from multiple paper-based or electronic-based forms (as applicable). It may include data elements from outside sources that are embedded in the records.

Verbal Communication. This authorization allows for verbal communication (both in person and on the telephone) between Communication Development Program (CDP) staff and the designated person(s) or organization(s) on this form (Sections 2 & 3). In addition, an option is provided to allow for CDP staff to leave voice messages on a messaging system for the person(s) or organization(s) listed in Section 3. This is to provide more timely communication.

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 Health Care Privacy Laws: These laws protect the confidentiality of heath care records and they indicate when records may be disclosed without your 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, Communication Development Program (CDP) Providers may not refuse to provide you 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 financial coverage, your revocation may not be effective in certain circumstances where the payer is contesting a claim. Your revocation must be made in writing and addressed to: Communication Development Program (CDP) at the address listed above.

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 Communication Development Program (CDP) staff (see address above).

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 situations in which this general rule does not apply. For more information regarding who is authorized to sign this form please direct questions to Communication Development Program (CDP) staff (see address above).