Patient Name

DOB:

MR #

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Date: ___________________________________

SwedishAmerican – A Division of UW Health
(University of Wisconsin Hospitals and Clinics Authority)

AUTHORIZATION FOR VERBAL DISCLOSURE OF HEALTH INFORMATION AND/OR TO LEAVE VOICE MAIL MESSAGES

1. **PATIENT INFORMATION: Please print clearly. All information must be provided**

   Full Legal Name: ___________________________________

   Current Address: ___________________________________

   Telephone Number: ___________________________ Date of Birth: ______________

2. **INFORMATION TO BE DISCLOSED:** Verbal communication only: Patient's care – no copies of medical records provided

   ☐ Yes ☐ No I authorize the following type(s) of sensitive information pertaining to my care: mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS) HIV test results and/or information, unless I limit the disclosure to exclude the following (if Yes, witness signature is needed):

   ____

3. **VERBAL COMMUNICATION BETWEEN:**

   ___________________________ And: Name: ___________________________

   (list name of health care facility or specific health care provider/staff member. Listing "SwedishAmerican" will cover all SwedishAmerican locations)

   (list first and last name of person(s) to whom your confidential information may be disclosed, such as a community social worker)

   AND/OR

   Leave VOICE MAIL at the Following Phone Number(s) ___________________________

   ___________________________ (voice mail includes any information, unless limited below):

   Limit voice mail only to information specified: ___________________________

   AND/OR

   Leave MESSAGE WITH AN INDIVIDUAL who answers the phone at the number provided above
   Please specify:
   ☐ Anyone ☐ Name(s) of authorized individual(s): ___________________________

4. **PURPOSE OF COMMUNICATION:** Continued Care, unless specified: ___________________________

   ____

5. **THIS AUTHORIZATION WILL EXPIRE** in one year from signature unless otherwise indicated below:

   ☐ Other specific expiration date or event (specify): ___________________________ (mm/dd/yyyy)

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

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6. PLEASE READ THE FOLLOWING CAREFULLY:

I understand that I may revoke this Authorization in writing at any time except to the extent information was released or other action taken in reliance on it. Any written revocation must be signed by the patient or legal representative, witnessed, and delivered to the Privacy Official, SwedishAmerican Health System, 1401 East State Street, Rockford, Illinois, 61104.

I understand the potential for further disclosure by recipients of the information to persons who may not be subject to privacy or confidentiality protections.

I understand that the above identified health information may contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS) HIV test results and/or information.

I understand that I have the right to inspect and copy the information that is requested to be released pursuant to this Authorization.

I understand that I may refuse to sign this Authorization and that no treatment, payment or benefits are conditioned upon my providing this Authorization. If I refuse to sign this Authorization, I understand that the disclosure described above cannot be made unless it is authorized or required by law.

Signature of Patient/Representative: ______________________________ Date: _____/_____/_____Time: ___________

Signature of Witness: ____ Date: _____/_____/_____Time: ___________
If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: ____ Relationship: __________________________________

- Patient is: ☐ Minor ☐ Incompetent/Incapacitated
- Legal Authority: ☐ Legal Guardian ☐ Parent of Minor
  ☐ Health Care Agent ☐ Other: ____________________________

Reviewed by: ____Date: _____/_____/_____Time: ___________

****Clinic Staff: Once this document is completed, please fax to HIMS at (779) 256-2402****