

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

### INDIVIDUAL / AGENCY BEING AUTHORIZED TO DISCLOSE PHI

NAME OF INDIVIDUAL / AGENCY		TELEPHONE NUMBER	FAX NUMBER
ADDRESS	CITY	STATE	ZIP CODE

### SUBJECT OF PROTECTED HEALTH INFORMATION (PATIENT)

PATIENT NAME	DOC NUMBER	HOUSING UNIT	DATE OF BIRTH	TELEPHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE	

### RECIPIENT OF PROTECTED HEALTH INFORMATION

NAME OF INDIVIDUAL / AGENCY		TELEPHONE NUMBER	FAX NUMBER
ADDRESS	CITY	STATE	ZIP CODE

**NOTICE:** Records of the Department of Corrections that contain Protected Health Information (PHI) may include a Division of Adult Institutions and/or Division of Juvenile Corrections Health Care Record, Social Services File or Division of Community Corrections file. The records include those created by DOC and non-DOC health care providers. Disclosure of PHI can be written, electronic or verbal.

**READ CAREFULLY AND CHECK APPROPRIATE BOXES.**

### SPECIFIC PROTECTED HEALTH INFORMATION AUTHORIZED FOR USE/ DISCLOSURE

**Two-Way Release** By checking this box, I authorize the individuals/agencies named in this authorization, to disclose to each other, the PHI identified below on an ongoing basis for the duration of this authorization.

**Check the box to the left if a copy of an entire record may be disclosed and explain below why the entire record is needed.** Entire record includes all the types of information listed below plus correspondence, consents/refusals, medication administration sheets, flow sheets and miscellaneous documents. **If this box is checked, no checkboxes in the section below need to be checked. If no start and end dates are given below, only the last 12 months will be provided.**

### DOCUMENTS AUTHORIZED FOR USE/DISCLOSURE

- |  |  |
|--|--|
| <input type="checkbox"/> Problem List                                | <input type="checkbox"/> Medical Imaging Reports (X-Rays, MRIs, etc.)  |
| <input type="checkbox"/> Record of Immunizations and TB test Results | <input type="checkbox"/> Psychiatric (may include AODA/SUD diagnoses)  |
| <input type="checkbox"/> Medical History/Physical Exam               | <input type="checkbox"/> Psychological (may include AODA/SUD diagnoses)  |
| <input type="checkbox"/> Progress Notes                              | <input type="checkbox"/> AODA / SUD Program/Treatment Information  |
| <input type="checkbox"/> Prescriber's Orders/Medications             | <input type="checkbox"/> Optical   |
| <input type="checkbox"/> Consultations                               | <input type="checkbox"/> Dental  |
| <input type="checkbox"/> Laboratory Results                          | <input type="checkbox"/> Patient Request Folder/OnBase (e.g. Health Service Requests, Medication/Medical Supply Refill Requests) |

**THIS AUTHORIZATION MAY INCLUDE MEDICAL, MENTAL HEALTH, DEVELOPMENTAL DISABILITY AND ALCOHOL/DRUG ABUSE/SUBSTANCE USE DISORDER INFORMATION, AND HIV TEST RESULTS, UNLESS EXCLUDED BELOW.**

**Describe time period of records by entering start and end dates.** If no dates are entered, records for the most recent 12 months will be provided.

FROM:

TO:

If Authorization is **limited** to specific medical or mental health conditions(s), describe:

**LOCATION:** I authorize the disclosure of my location knowing that this will reveal that I am in a mental health or AODA / SUD treatment facility.

### PURPOSE OR NEED FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (check applicable category)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Ongoing health care/treatment                              | <input type="checkbox"/> Review by patient               | <input type="checkbox"/> Legal representation/proceedings (Court/Administrative) |
| <input type="checkbox"/> Coordination of care or eligibility for services/benefits. | <input type="checkbox"/> Review by family member/friend. |  |
| <input type="checkbox"/> Other  |  |  |

PATIENT NAME

DOC NUMBER

**PATIENT RIGHTS**

Right to Receive Copy of This Authorization. Patients have a right to receive a copy of this form after signing it.

Right to Refuse to Sign This Authorization. DOC can not condition treatment or payment for treatment based on a patient's decision not to sign this form, except for research-related treatment and provision of health care solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization. Patients have the right to revoke this Authorization at any time by completing a Revocation of Authorization for Use/Disclosure of PHI (DOC-1163R), or equivalent. Revocation is effective when DOC, or other individual/agency authorized to disclose PHI, receives the form, and is not effective regarding the uses/disclosures of PHI made prior to receipt of the DOC-1163R, or equivalent.

Re-disclosure. If a patient authorizes disclosure to an individual/agency not covered by laws that prohibit re-disclosure, the PHI may be re-disclosed by that individual/agency.

Right to Inspect and/or Copy PHI. Patients have the right to inspect, and obtain copies of PHI for a reasonable fee used/disclosed based upon this form.

Authority to Sign DOC-1163A. A **minor** is a person under the age of 18 years. An **adult** is a person 18 years or older.

- Adults can sign the form regarding all types of PHI about themselves.
- A court appointed guardian of the person or an agent under an activated Power of Attorney for Health Care (POAHC) can sign the form for the incompetent adult or principal regarding all types of PHI, unless restricted by the Letters of Guardianship or POAHC document.
- A parent/guardian can sign the form for a minor child regarding medical/ physical health, mental health and developmental disability information.
- Minors 12-17 years can sign the form for AODA / SUD information about themselves. A parent/guardian can **not** access or authorize disclosure of AODA / SUD information about a minor child 12-17 years without consent of the minor.
- Minors 14 -17 years old can sign the form regarding mental health and developmental disability information about themselves from a community provider whose records are covered by s. 51.30, Wis. Stats.
- Minors 14 -17 years can sign the form regarding HIV test results about themselves. A parent/guardian can **not** access or authorize disclosure of HIV information about a minor child 14-17 years without consent of the minor.

**AUTHORIZATION EXPIRATION: DATE/EVENT**

**This Authorization is in effect until the following date or event:** \_\_\_\_\_

**If no date/event is entered, this Authorization expires one year from the date of signing.**

**I have read or had read to me this Authorization form. I have had an opportunity to ask questions. By signing this Authorization, I am confirming that it accurately reflects my wishes regarding use and disclosure of my Protected Health Information.**

SIGNATURE OF PATIENT		DATE SIGNED
SIGNATURE OF OTHER PERSON LEGALLY AUTHORIZED TO CONSENT TO DISCLOSURE (if Applicable)	TITLE OR RELATIONSHIP TO PATIENT	DATE SIGNED

**LIST OF DOCUMENTS/INFORMATION DISCLOSED BASED UPON THIS AUTHORIZATION**  
(Write on back-side of form or attach additional sheets if needed, include name and DOC number on each sheet)

INITIALS OF PERSON DISCLOSING PHI \_\_\_\_\_ DATE DISCLOSED \_\_\_\_\_ TIME DISCLOSED \_\_\_\_\_

**FACSIMILE OR PHOTOCOPY CAN BE TREATED AS ORIGINAL**

**DISTRIBUTION:** Original – Internal Paper Record, PR Authorization Section; Social Services File, Release of Information Authorizations Section; PSU Record AODA / SUD Envelope or DCC Offender Case File; Copy - Individual/Agency authorized to disclose PHI when other than DOC Copy - Patient /Other Person signing form