This does not authorize release of <u>copies</u> of medical records –
Use #100025 or 100025-1 Authorization for Release of Information

1. **Patient Information**

Name – Last, First, MI		
Street Address		
	State	Zip
Medical Record Number	Date of Birth	Phone Number

2. **Information to be Disclosed:** Verbal communication only – no copies of records provided

3. **Communication Between:**
<u>UnityPoint Health-Meriter Hospital and Clinics – 202 S. Park Street, Madison, WI 53715</u> **and:**

Name:	Phone Number:	Relationship:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

4. **Purpose of Communication:** Continued Care unless specified: _____

5. **This authorization will expire** in one year from signature unless otherwise indicated below:

☐ Ends on (date) _____

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

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. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and/or HIV test results (if applicable) unless I limit the discussion to exclude the following medical conditions:

_____

6. SIGNATURE OF PATIENT: _____ **DATE SIGNED:** _____

7. SIGNATURE OF AUTHORIZED PERSON (If applicable)**:** _____ **DATE SIGNED:**_____
If signed by other than patient, state relationship and authority to do so.

8. PRINTED NAME OF AUTHORIZED PERSON _____ **DATE SIGNED:**_____

Legal Authority: ☐ Legal Guardian (Attach court action) ☐Next of Kin (Spouse, if living)
☐Power of Attorney (Attach POA for Health Care papers) ☐ Parent of Minor *Proper legal documentation must be on file

UnityPoint Health Meriter

PARTNER OF UW Health

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

UnityPoint Health-Meriter Hospital and Clinics honor a patient's right to confidentiality of medical information as provided under federal and state law.

Please read the following guidelines before signing this authorization.

Sending Authorizations to UnityPoint Health-Meriter Hospital: If mailing an authorization, please mail to:

UnityPoint Health-Meriter Hospital and Clinics
Health Information Management
202 S. Park Street
Madison, WI 53715

Verbal Communication Only. This authorization allows for verbal communication between UnityPoint Health-Meriter Hospital and Clinics and the designated person on this form. It does not allow for copies of medical records to be released.

No Obligation to Sign. You are not under any obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, UnityPoint Health-Meriter Hospital and Clinics 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, 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 insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to the appropriate originating organization:

- **UnityPoint Health-Meriter Hospital and Clinics:** 202 S. Park Street, Madison, WI 53715 or fax number 608-417-6016

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.

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 many situations in which this general rule does not apply. For form information regarding who is authorized to sign this form, contact the appropriate originating organization:

- **UnityPoint Health-Meriter Hospital and Clinics:** Health Information Management at 608-417-6406.