Public Health
MADISON & DANE COUNTY
Healthy people. Healthy places.

PUBLIC HEALTH MADISON AND DANE COUNTY (PHMDC)
AUTHORIZATION TO RELEASE AND/OR OBTAIN HEALTH INFORMATION

1. Client/Patient Information

Name of Individual/Previous Name(s)	Date of Birth (mm / dd / yyyy)	(_____)_____ Daytime Phone #
Street Address or PO Box	City	State Zip

2. I authorize Public Health Madison and Dane County (PHMDC) to release health information and medical records to, OR obtain health information and medical records from, the healthcare provider, agency, organization, or individual listed below:

Name of healthcare provider, agency, organization, or individual	Client/Patient's Provider ID # (Optional)

Street Address	City	State	Zip	(_____)_____ Phone

3. I authorize verbal exchange of medical information regarding my care and treatment between "the above listed health care provider, agency, organization, or individual, including my treating physician and their staff" and "PHMDC (or other representative of PHMDC), specifically with my Public Health Nurse:" _____
Name of Public Health Nurse & Phone Number

4. Medical Information or Specific Health Issue to be Released/Obtained/Verbally Exchanged:

_____

_____

5. Exceptions to this authorization include (specify record or information): _____

6. Purpose for which the disclosure is being made: (Check all that apply)
☐ Referral ☐ Ongoing Care and Treatment ☐ Disability Determination ☐ Legal investigation ☐ Other _____

7. Disclosures Requiring Special Consent: My signature below specifically authorizes the release of health information relating to testing, diagnosis and treatment for the following checked categories:
☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol and/or Drug Abuse ☐ HIV & AIDS

8. Expiration Date: This authorization is valid for one year, unless otherwise stated, and extends to future records created after the date of signature, alternate date, or event, as long as such treatment and services occur while this authorization is still in effect.

Alternate date/ event if not one year: _____ or _____
Date (mm / dd / yyyy) Event

9. Is this authorization for paper records? ☐ Yes ☐ No

10. To release paper medical records to PHMDC, fax/send records to: (Please check location below.)

☐ 210 Martin Luther King, Jr. Blvd., Rm. 507
Madison, WI 53703-3346
Fax: (608) 266-4858

☐ 2705 E. Washington Ave.
Madison, WI 53704
Fax: (608) 266-4858

☐ 2300 S. Park St., Rm. 2010
Madison, WI 53713
Fax: (608) 266-4858

_____ _____
Client/Patient Signature Date (mm / dd / yyyy)

_____ _____
*Signature of Parent of a Minor, Guardian or Authorized Agent. Date (mm / dd / yyyy)

Please describe your authority: _____
*If signed by the parent of a minor, I hereby declare that I have not been denied physical placement of this child or denied access to this child's records. If a Guardian, please provide a copy of the current Letters of Guardianship. If signed by an Agent under Power of Attorney, please provide a copy of the Power of Attorney and Statement of Incapacity.

Reference: WI Statutes 146.82, 51.30, 252.15 & HIPAA requirements 42 CFR Part 2 & 45 CFR Part 164.

Revised 10/14/2015 ☐ **Retain Copy in Record (yellow)** ☐ **Client Received Copy**

ADDITIONAL INFORMATION REGARDING USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The HIPAA Privacy Rule requires Public Health Madison and Dane County (PHMDC) to make sure that your protected health information is kept confidential and not disclosed to anyone or used by anyone without your consent, authorization, or unless specifically allow by law.

No Obligation to Sign: You are under no obligation to sign this form and you may refuse to do so. Unless requested information is necessary to ensure proper treatment, PHMDC will 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 individual, agency or organization listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it.

Right to Inspect and Copy: You have the right to inspect and to receive a copy of a designated set of your medical records that we maintain, including in an electronic format. If you request release of health information for further medical care, no fees will be charged. We may charge a reasonable fee for the costs of copying and mailing for other purposes.

Expiration: This authorization will expire on the date or by the event indicated on this form.

Redisclosure of Information: Information disclosed pursuant to this authorization is not protected by federal privacy laws to the extent that entities obtaining this information are not required by law to keep such information confidential.

Consequences of Refusal to Sign: We will not deny you services if you refuse to sign this authorization, but we may be limited in what services we can provide you without having necessary access to information about you.

Signatures: If you are 18 years of age or older, you are the only person who can sign this form to authorize the release or 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 more information regarding who is authorized to sign this authorization form, contact the PHMDC Privacy Office.

Right to a Copy: You have a right to a copy of this authorization after signing it.

Contact Us: For more information regarding your rights under the HIPAA Privacy Rule and other federal and state laws, to obtain a copy of the PHMDC Notice of Privacy Practices, to revoke an authorization, or to register a complaint, please contact the PHMDC Privacy Officer at:

Privacy Officer
Public Health Madison and Dane County
210 MLK Blvd., Room 507
Madison WI 53703
Phone: (608) 266-4821; Fax: (608) 266-4858; E-mail at health@publichealthmdc.com

You may contact the PHMDC Privacy Officer for a copy of our Notice of Privacy Practices or visit our website at http://www.publichealthmdc.com/about for a copy.