

ASSOCIATED PHYSICIANS, LLP
DISCLOSURE AUTHORIZATION FORM

Note: This form is used to confirm an enrollee’s authorization for Associated Physicians, LLP to discuss or disclose his/her protected health information to the person or persons listed on this form. Use of patient information is strictly limited to that purpose described above.

Section A: Enrollee Information

By signing this form in Section E below, I understand and agree that Associated Physicians, LLP may release my personal health information as defined in Section B below to the individual(s) named in Section C below.

Patient Name: _____

Address: _____

Telephone Number: _____

E-mail Address: _____

Section B: Type of Information NOT to be Shared

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Personal Representative’s access to information about a particular health care provider or a particular record. Any such limitations must be described below in writing. *I understand that by leaving this section blank, I am creating no limitations on disclosure.*

Billing, insurance, and collections information

Healthcare treatment and records

Lab and other test results

Other: _____

Specific Authorization for Mental Health, Substance Abuse Treatment or AIDS-Related Information:

I authorize the release and disclosure of any and all personal health information, including specifically mental health information, substance abuse (drug or alcohol), and AIDS or HIV-related information, if applicable, and all claims information to the individual named below as long as this authorization is in effect. I understand that I may inspect the mental health information disclosed.

Initials: _____

Section C: Authorized Use and/or Disclosure
Intended Use or Disclosure:

I understand that it is the policy of Associated Physicians to not disclose a patient's personal health information to other parties without the patient's authorization, except when permitted or required by law. For this reason, I authorize Associated Physicians to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating my healthcare or health plan

benefits. I also understand that if the individual(s) named below is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and may be subject to further disclosure without my authorization. I acknowledge that my authorization is voluntary, and that signing this authorization is not required in order to receive treatment or be eligible for benefits.

Recipient #1:

Name: _____

Phone Number: _____

Address: _____

Relationship to You: _____

Recipient #2:

Name: _____

Phone Number: _____

Address: _____

Relationship to You: _____

Section D: Expiration and Revocation

This authorization will automatically expire two years following the termination of my health plan enrollment. I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named in Section C to receive my personal health information, I must revoke this authorization **in writing** by giving written notice of my decision to the contact person named below. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

Contact: Privacy Officer, Associated Physicians, LLP

Address: 4410 Regent St, Madison, WI 53705

Section E: Signature / Authorization

I have had full opportunity to read and consider the content of this authorization. I confirm that this authorization is consistent with my request of Associated Physicians, LLP. I understand that, by signing this form, I am confirming my authorization that Associated Physicians, LLP may use and/or disclose my personal health information to the person(s) named in Section C for the purpose described above.

Signature and Date

Please return the signed authorization form to the clinical reception desk or contact person listed in Section D. You are entitled to a copy of this authorization form after you sign it.

_____/_____
Signature of Patient *Date*

_____/_____/_____
Signature of Personal Rep *Relationship to Patient* *Date*