

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

NAME	IDENTIFYING/DOC NUMBER	DATE OF BIRTH	TELEPHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE

PHI CAN BE DISCLOSED TO

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

SPECIFIC INFORMATION AUTHORIZED FOR DISCLOSURE

INSTRUCTIONS: This authorization permits use and disclosure of PHI identified below contained in any Department of Corrections (DOC) record (e.g. Health Care Record, Social Services File or Division of Community Corrections file), created by DOC and non-DOC health care providers. Disclosure of PHI can be written, electronic or verbal.

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

If requesting entire record, explain why entire record is needed:

Check the category(ies) of information authorized for use or disclosure.

MEDICAL (Physical Health)

Describe Medical Condition(s) _____

Identify Time Period Of Records (Be Specific): _____

Description of PHI diagnosis/prognosis progress notes/summaries treatment/health care plan(s)
 medications laboratory reports/x-rays physician's orders optical dental

MENTAL HEALTH

Psychological Psychiatric Social Work (Counseling / Therapy)

Describe Mental Condition(s) _____

Identify Time Period Of Records (Be Specific): _____

Description of PHI assessment/diagnosis treatment plan(s) progress notes/summaries other:

ALCOHOL AND DRUG INFORMATION – (Disclosing individual/agency shall attach statement prohibiting re-disclosure required by 42 C.F.R. s. 2.32)

Alcohol & Drug Alcohol Only Drug Only

Identify Time Period Of Records (Be Specific): _____

Description of PHI assessment/diagnosis treatment plan(s) progress notes/summaries other:

DEVELOPMENTAL DISABILITY

Condition(s) _____

Identify Time Period Of Records (Be Specific): _____

Description of PHI assessment/diagnosis treatment plan(s) progress notes/summaries other:

HIV AND AIDS

Identify Time Period Of Records (Be Specific): _____

Description of PHI HIV test results treatment plan(s) progress notes/summaries other:

OTHER Describe:

Identify Time Period Of Records (Be Specific): _____

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

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

- Treatment/Care coordination
- Disability determination
- Review by subject of PHI
- Provision of PHI to outside parties
- Other _____
- Legal proceedings/reports
 - Court-ordered reports: Pre-Sentence Investigation, §972.15, Stats., and Dispositional Report (juvenile) , §938.33 Stats.
 - ch. 980 special purpose evaluation (DOC/DHFS or contract evaluator)
 - ch. 980 court proceeding (Department of Justice, circuit court, district attorney and defense attorney)
 - Revocation Hearing or other administrative hearing (Department of Justice, circuit court, district attorney and defense attorney)
 - Other

PATIENT RIGHTS WITH RESPECT TO THIS AUTHORIZATION

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. Patients are under no legal obligation to sign this form in order to receive health care in a DOC facility. DOC can not condition treatment or payment based on a patient’s decision not to sign this authorization, except regarding research-related treatment and provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization. Patients have the right to withdraw this authorization at any time by completing a Health, Dental or Psychological Services Request at a facility, or submitting a written statement to his/her agent when on DCC/DJC community supervision. Withdrawal of consent will be effective when DOC receives it, and will not be effective regarding the uses and/or disclosures of PHI made prior to receipt of the withdrawal statement.

Re-disclosure. If a patient authorizes disclosure of PHI to an individual or agency not covered by laws that prohibit re-disclosure, the PHI may not remain confidential and may be re-disclosed by the recipient.

Right to Inspect and/or Copy PHI. Upon the signing of this form, patients have the right to inspect, and obtain copies of their PHI for a reasonable fee, with some limited exceptions.

HIV Test Results. HIV test results can be disclosed without patient authorization under s. 252.15(5)(a), Wis. Stats., as described in the publication, HIV Information Regarding Testing and Disclosure (POC-11), available to patients upon request.

AUTHORIZATION INFORMATION AND SIGNATURE

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 information about themselves. A parent/guardian can **not** access or authorize disclosure of AODA 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.
- 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.

YOU MUST INITIAL ONLY ONE BOX BELOW. ENTER THE INFORMATION REQUESTED FOR THAT LINE.

	Authorization expires as of the following date _____ .
	Authorization expires _____ month(s) from the date I sign this authorization.
	Authorization expires when the following action/event takes place: (e.g. release from incarceration, discharge from supervision, or end of legal proceeding.) _____

I have read or had read to me the contents of this authorization. I have had an opportunity to discuss and ask questions. By signing this authorization, I am confirming that it accurately reflects my wishes regarding use and disclosure of my PHI.

SIGNATURE OF INDIVIDUAL WHO IS SUBJECT OF PHI	DATE SIGNED
SIGNATURE OF OTHER PERSON LEGALLY AUTHORIZED TO CONSENT TO DISCLOSURE (If Applicable)	TITLE OR RELATIONSHIP TO INDIVIDUAL WHO IS SUBJECT OF PHI
	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- Individual/Agency authorized to disclose PHI; Copy-Patient /Other Person signing form; Copy - Record from which PHI is being disclosed