patientcare
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Authorization for Disclosure of Protected Health Information
(Form to Use When Someone Calls Patient Care About Another Person)

This form is used for a Patient Care member to authorize another individual to receive and access the member's protected health information which is obtained by Patient Care to resolve a specific health care issue on behalf of the member. Information to be disclosed will be directly related to the issue to be resolved and may include complete health record(s), photographs, videotapes, x-rays, digital or other images, and genetic health information. This information may also include information relating to AIDS or HIV, psychiatric care, treatment for alcohol and/or drug abuse, and genetics.

You may restrict the information to be disclosed by indicating below the protected health information that you want handled in a restricted manner and the restriction you want Patient Care to apply:

_____

SECTION A : MEMBER INFORMATION (Items with a * are required to be completed)

*Name: _____ *Address: _____

*City: _____ *State: _____ Zip: _____

*Social Security No: _____ Telephone: _____

Employer: _____

SECTION B : AUTHORIZED RECIPIENT(S) (Person who will receive your information) (Items with a * are required to be completed)

Person #1	Person #2
*Name: _____	*Name: _____
*Address: _____	*Address: _____
*City/State/Zip: _____	*City/State/Zip: _____
*Social Security No.: _____	*Social Security No: _____
Relationship to member: _____	Relationship to member: _____

Expiration: This authorization will automatically expire upon termination of membership in Patient Care.

Right to Revoke: You may revoke this authorization at any time, except to the extent that action or release has been taken in reliance on this authorization, by giving written notice to:

Patient Care Privacy Office
633 W Wisconsin Ave, Ste 1310
Milwaukee, WI 53203
Telephone: (414) 271-1790 Fax: (414) 271-1795

I understand that if my protected health information is disclosed to and/or received by the person(s) named in this authorization who are not subject to federal health information privacy laws, they may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

I understand that by signing this form, I am authorizing Patient Care to use and/or disclose to the person(s) named in this form the protected health information described above. Patient Care, its employees and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

Signature: **X**_____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

A personal representative is a legal designation and generally refers to parent of an unemancipated minor, Legal Guardian, or holder of Power of Attorney. Attach legal documentation of Legal Guardian or Holder of Power of Attorney.

Please complete and return this form to: Patient Care Privacy Office
633 W Wisconsin Ave, Ste 1310, Milwaukee, WI 53203
Fax: (414) 271-1795