Group Health Cooperative of South Central Wisconsin

Authorization to Allow Verbal Communication and/or Leave Detailed Messages

1. Patient Information

Name – Last, First MI ____________________

Street Address ____________________ City ____________ State ________ Zip ______

Medical Record/Member #: ____________ Date of Birth: ____/____/____ (MM DD YY) Phone Number: ____________

2. Information to be disclosed

I hereby authorize GHC-SCW to engage in verbal communication or to leave a detailed message with the individual(s) or organization(s) identified below for the following purposes:

All aspects of my care treatment and payment, including insurance, benefits and claims

All clinical care, including test results and visit documentation

All billing and insurance information

Schedule, cancel, reschedule or obtain information about my appointments

Other (Describe): ____________________

3. Restrictions: ____________________

4. Verbal Communication Between:

Name/Relationship: ____________________ and: Name/Relationship: ____________________

(List the name of the health care facility or specific health care provider/staff member. Listing "GHC-SCW" will cover all GHC-SCW locations)

(List the first and last name of the individual(s) to whom your protected health information may be disclosed.

Additional authorized individual(s) or organization(s):

Name/Relationship: ____________________ and: Name/Relationship: ____________________

5. Leave Detailed Message With:

Myself:

Phone #1: ____________________ and/or Phone #2: ____________________

Authorized individual(s) or organization(s):

Individual #1: ____________________ Relationship: ____________ Phone #: ____________

Individual #2: ____________________ Relationship: ____________ Phone #: ____________

Conditions of Authorization:

1. I understand that this authorization does not include obtaining copies of electronic or paper medical records.
2. I understand that if I agree to sign this authorization, I may request a signed copy of the form.
3. I understand that interaction with another individual may be denied if determined to be in my best interest.
4. I understand that detailed messages may not be left with me or another individual if determined to be in my best interest.
5. I understand that this authorization references all aspects of my healthcare at GHC-SCW, including Mental Health and AODA, unless I have indicated any restrictions on this form.
6. I understand that I am fully responsible for reporting changes to data or named individuals.
7. I understand that this authorization may be revoked in writing at any time by contacting the GHC-SCW HIM department at (608) 441-3500, option 1.
8. Authorizations are executed in compliance with federal and state laws governing this action.
9. I understand that this authorization is executed in compliance with federal and state laws.
10. This authorization is effective on the date of signature and **expires after one (1) year** unless indicated otherwise here: ____/____/____ (MM DD YY)

Signature of Patient or Legal Representative: ____________________ **Date:** ____/____/____ (MM DD YY)

Relationship: ____________________

Patient is: Minor Incompetent/Incapacitated Deceased

Legal Authority:

Legal Guardian Spouse of Deceased Health Care Agent Personal Representative Other: ____________

Patient: Give completed form to GHC-SCW employee **GHC-SCW:** Route form to Release of Information Department at East Clinic

BETTER TOGETHER℠

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ghcscw.com