Reset

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/YYYY) / /	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 healthcare facility or specific healthcare 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 / YYYY)

Signature of Patient or Legal Representative: _____ **Date:** _____/_____/_____ (MM / DD / YYYY)

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 Health Information Department at Admin.