Hospital Sisters
HEALTH SYSTEM

Patient Label

AUTHORIZATION TO COMMUNICATE HEALTH AND BILLING INFORMATION TO DESIGNATED PERSONS

As the patient, I understand that I am the primary person to receive information from physicians and other caregivers regarding my health condition, treatment and progress. However, other individuals may desire or have a need to receive information about my condition and health care services. I authorize the staff & physicians at Hospital Sisters Health System on its own behalf and on behalf of all its affiliate hospitals and entities and Prevea Health (identified as "HSHS") to provide verbal information about my **TREATMENT** (health, plan of care, treatment, appointments, and my condition) and **BILLING** (information about my account in order to assist me with my insurance and payments) to the persons named below for the purpose of keeping them informed of my progress or assisting with my care. (Please note, we reserve the right to utilize clinical judgment in determining with whom we need to communicate based upon your health care needs, i.e. emergency situation.)

Patient Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip: _____

Telephone Number: _____

I hereby authorize HSHS to verbally disclose protected health information to the following: (I agree that this authorization includes the release or disclosure of alcohol/drug abuse, HIV test results, and Mental Health/Developmental Disabilities unless I check the applicable box below)

Name	Relationship	Telephone Number
Name	Relationship	Telephone Number
Name	Relationship	Telephone Number

☐ I decline HSHS verbally sharing my treatment information with others, excluding emergency situations as indicated above.

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):
☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities

☐ **Voice Mail**: Except for appointment reminders and billing inquiries, I understand that I will not be left voicemail messages regarding my health unless I agree to the following. I understand that messages left on voice mail may be subject to access by others and therefore are not a secure way to communicate confidential information. I understand that because of this risk HSHS advises that protected health information should not be left on voice mail. **By checking this box, I agree that HSHS may communicate my health information noted above to me via my voice mail at the number listed above** and I release HSHS and its employees, officers, and directors from all liability for any unintended disclosure or consequence as a result of communicating my protected health information to me in this manner.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may possibly be re-disclosed by the recipient, and/or no longer be protected by Federal privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to Information Disclosed - I understand that I have a right to know what information was disclosed to the above individuals. **Right to Receive a Copy of This Authorization** – I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form. Treatment, payment, enrollment or eligibility for benefits may not be based upon my decision to sign this authorization. **Right to Revoke This Authorization** – I understand that I may revoke this authorization. A description of how to revoke the authorization and any exceptions are included in the Notice of Privacy Practices. This notice is available through our facility website or at the patient registration desk. **HIV Test Results:** HIV test results are protected under Wisconsin state statute 252.15 and the Illinois AIDS Confidentiality Act (410 ILCS 305 et seq) may not be disclosed without written informed consent/authorization, except to persons or organizations that have been given access by state law. A list of those persons/organizations is available upon request.

EXPIRATION: I understand that this authorization will remain in effect until_____ **or** I choose to revoke it.
(Indicate event or date)

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name

If signed by a person other than the patient, complete the following:
1) Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2) Legal authority: ☐ parent* ☐ legal guardian ☐ activated POA for Health Care ☐ next of kin/executor of deceased
*By signing above, I hereby declare that I have not been denied physical placement of this child.

NC

Original: Chart Copy: Patient