DEPARTMENT OF CORRECTIONS
Division of Management Services
DOC-1163A (Rev. 2/2012)

WISCONSIN
Wisconsin Statutes
§§ 146.81-84, 252.15, 938.78 and 51.30
Federal Regulations
42 CFR Part 2 & 45 CFR Parts 160 & 164

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 (PATIENT)

PATIENT NAME	DOC NUMBER	HOUSING UNIT	DATE OF BIRTH	TELEPHONE NUMBER
ADDRESS		CITY	STATE	ZIP CODE

RECIPIENT OF PROTECTED HEALTH INFORMATION

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

NOTICE: Records of the Department of Corrections that contain protected health information (PHI) may include a Division of Adult Institutions and/or Division of Juvenile Corrections Health Care Record, Social Services File or Division of Community Corrections file. The records include those created by DOC and non-DOC health care providers. Disclosure of PHI can be written, electronic or verbal.
READ CAREFULLY AND CHECK APPROPRIATE BOXES.

SPECIFIC PROTECTED HEALTH INFORMATION AUTHORIZED FOR USE/ DISCLOSURE

THIS AUTHORIZATION APPLIES TO MEDICAL, MENTAL HEALTH, DEVELOPMENTAL DISABILITY AND ALCOHOL/DRUG ABUSE INFORMATION, AND HIV TEST RESULTS, UNLESS EXCLUDED BELOW.

I DO NOT want the following information disclosed.

☐ Medical (Physical Health) ☐ HIV Test Results ☐ Alcohol and Drug Abuse Diagnosis/Treatment ☐ Developmental Disability
☐ Mental Health ☐ Records related to a stay in a Division of Juvenile Corrections facility

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

☐ **Check the box to the left if a copy of an entire record may be disclosed and explain below why the entire record is needed.** Entire record includes all the types of information listed below plus correspondence, consents/refusals, medication administration sheets, flow sheets and miscellaneous documents. **If this box is checked, no checkboxes in the section below need to be checked**.

DOCUMENTS AUTHORIZED FOR USE/DISCLOSURE

☐ Problem List
☐ Record of Immunizations and TB test Results
☐ Medical History/Physical Exam
☐ Progress Notes
☐ Prescriber's Orders/Medications (no psychotropic meds if mental health excluded above.)
☐ Consultations
☐ AODA (diagnosis only) ☐ AODA Program/Treatment Information
☐ Psychiatric
☐ Psychological
☐ Laboratory Results
☐ Medical Imaging (X-Rays, MRIs, etc.)
☐ Dental
☐ Optical
☐ Patient Request Folder (e.g. Health Service Requests, Medication/Medical Supply Refill Requests)

Describe time period of records by entering start and end dates. If no dates are entered, records for the most recent 12 months will be provided. FROM: TO:

If Authorization is **limited** to specific medical or mental health conditions(s), describe:

☐ **LOCATION**: I authorize the disclosure of my location knowing that this 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)

☐ Ongoing health care/treatment ☐ Review by patient ☐ Legal representation/proceedings (Court/Administrative)
☐ Coordination of care or eligibility for services/benefits. ☐ Review by family member/friend.
☐ Other

Continued

PATIENT NAME	DOC NUMBER

PATIENT RIGHTS

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. DOC can not condition treatment or payment for treatment based on a patient's decision not to sign this form, except for research-related treatment and provision of health care solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization. Patients have the right to revoke this Authorization at any time by completing a Revocation of Authorization for Use/Disclosure of PHI (DOC-1163R), or equivalent . Revocation is effective when DOC, or other individual/agency authorized to disclose PHI, receives the form, and is not effective regarding the uses/disclosures of PHI made prior to receipt of the DOC-1163R, or equivalent.

Re-disclosure. If a patient authorizes disclosure to an individual/agency not covered by laws that prohibit re-disclosure, the PHI may be re-disclosed by that individual/agency.

Right to Inspect and/or Copy PHI. Patients have the right to inspect, and obtain copies of PHI for a reasonable fee used/disclosed based upon this form.

Authority to Sign DOC-1163A. A **minor** is a person under the age of 18 years. An **adult i**s 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 from a community provider whose records are covered by s. 51.30, Wis. Stats.
- 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.

AUTHORIZATION EXPIRATION: DATE/EVENT

This Authorization is in effect until the following date or event: _____

If no date/event is entered, this Authorization expires one year from the date of signing.

I have read or had read to me this Authorization form. I have had an opportunity to ask questions. By signing this Authorization, I am confirming that it accurately reflects my wishes regarding use and disclosure of my Protected Health Information.

SIGNATURE OF PATIENT		DATE SIGNED
SIGNATURE OF OTHER PERSON LEGALLY AUTHORIZED TO CONSENT TO DISCLOSURE (If Applicable)	TITLE OR RELATIONSHIP TO PATIENT	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 - Medical Chart, Consents/Refusals Section; or PSU Record, Legal Documents/Consents/Outside Records Section; Legal File, Right Side or Social Services File, Confidential Envelope; or Division of Community Corrections Supervision File; Copy - Individual/Agency authorized to disclose PHI when other than DOC Copy - Patient /Other Person signing form