

**Upper Midwest Common Consent Form**  
**For Full Disclosure of Health Information for Treatment, Payment & Health Care Operations**

\*\*\*PLEASE READ THE ENTIRE FORM, ALL PAGES, BEFORE SIGNING BELOW\*\*\*

**Patient (name and information of person whose health information is being disclosed):**

Name (First Middle Last): \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*You may use this form to allow your healthcare providers and payors to disclose, access and use your health information from services provided in Illinois, Minnesota, North Dakota, South Dakota or Wisconsin. Your choice on whether to sign this form will not affect your ability to get health care or health insurance coverage and cannot be used as the basis for denial of health services.*

**By signing this form, I voluntarily authorize and give my permission and allow disclosure:**

**OF WHAT:**

**ANY OF MY HEALTH INFORMATION from services provided in Illinois, Minnesota, North Dakota, South Dakota, or Wisconsin, including any information about sensitive conditions** (if any) [See page 3 for details];

Disclosure of health information located in Illinois will not occur unless consent is granted with respect to all applicable information below.

\_\_\_ If you do not have any health information for services provided in Illinois, check here.

**Note Regarding Disclosure of Health Information Located in Illinois:** To authorize the disclosure of health information for services provided in Illinois, **you must initial *all*** of the categories of information listed below **to the extent that they apply to you:**

- \_\_\_ HIV/AIDS related health information and/or records
- \_\_\_ Information about sexually transmitted diseases
- \_\_\_ Drug/alcohol diagnosis, treatment, and /or referral information
- \_\_\_ Genetic testing information and/or records
- \_\_\_ Information about sexual assault/abuse
- \_\_\_ Information about child abuse and neglect
- \_\_\_ Abuse of an adult with a disability

Failure to initial all of the categories that apply will render this consent invalid for disclosure of any of your health information for services provided in Illinois. If you want only a portion of your health information shared, you need to use a patient consent form for limited disclosure of health information, instead of this form.

If you want to disclose mental health or developmental disability information and/or records (including psychotherapy notes as defined in the federal HIPAA Privacy Rule at 45 CFR 164.501), an additional authorization is required.

\_\_\_ If your health services were provided Illinois **but none of it falls within any of the categories above**, check here and all of your health services provided in Illinois will be disclosed.

**FROM WHOM:** ALL information sources [See page 3 for details]

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**TO WHOM:** Specific person(s) or organization(s) permitted to receive my information (must be a health care provider):

Person/Organization Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**PURPOSE:** To provide me with health care treatment and related services, to facilitate payment for services, and to support health care operations.

**EFFECTIVE PERIOD:** This consent/permission form will remain in effect until the day I withdraw my permission or until the date specified here \_\_\_\_\_, whichever occurs first.

**WITHDRAWING MY PERMISSION:** I can withdraw my permission at any time by giving written notice to the person or organization named above in "To Whom," subject to the details of "Withdrawal" on page 3.

**In addition:**

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.

I understand that there are some circumstances in which this information may be redisclosed to other persons and that the recipient of redisclosed information may be controlled by different laws. [See page 3 for details].

I understand this authorization is voluntary and I am under no obligation to sign this form and no organization may condition treatment, payment, enrollment, or eligibility for benefits on signing this form.

**I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization, consent, or permission. I have read all pages of this form including the explanation that follows and agree to the disclosures.**

X \_\_\_\_\_  
Signature of Patient or Patient's Legal Representative

\_\_\_\_\_  
Date Signed (mm/dd/yyyy)

X \_\_\_\_\_  
Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- Parent of minor
- Guardian
- Other personal representative (specify): \_\_\_\_\_

**NOTE:** Under some state laws, minors must consent to the release of certain information. The law of the state from which the information is to be released determines whether a minor must consent to the release of the information.

**This form is invalid if modified. You are entitled to get a copy of this form after you sign it. You may have a right to inspect, and upon paying any applicable fees, obtain a copy of the disclosed records.**

# Upper Midwest Common Consent Form For Full Disclosure of Health Information for Treatment, Payment & Health Care Operations

## Explanation of Form

Laws and regulations require that an individual give written consent for the disclosure of some sources of identifiable health information. Also some laws require specific consent for the disclosure of information about certain conditions.

"Of What" includes: ANY OF YOUR HEALTH INFORMATION, including:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care that is held by or on behalf of providers and/or payors located in Illinois, Minnesota, North Dakota, South Dakota, or Wisconsin. This information may relate to sensitive health conditions (if any), including but not limited to:**
  - a. Drug, alcohol, or substance abuse
  - b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501 in any state, and any Illinois mental health or developmental disability information and/or records, all of which require additional authorization)
  - c. Pregnancy, birth control and family planning
  - d. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
  - e. Genetic (inherited) diseases or tests
  - f. Sexual assault/abuse
  - g. Child abuse and/or neglect
  - h. Domestic abuse of an adult with a disability
2. **Information created before or after the date of this form.**

"From Whom" includes: **All information sources** including (if applicable), but not limited to, health care providers, plans and payors (including hospitals, clinics, labs, pharmacies, physicians, psychologists, alcohol and drug treatment programs, health care insurers, Medicare and Medicaid, etc.).

"To Whom": For those health care providers listed in the "To Whom" section, your permission also includes physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange. "To Whom" may also include health plans that provide payment for services rendered such as a commercial insurance, Medicare or Medicaid.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance. You can make that choice in a separate form that health insurers use. For purposes of this consent, "treatment", "payment," and "health care operations" have the same meaning as defined under the federal HIPAA Privacy Rule at 45 CFR 164.501. "Health care operations" are broadly viewed or defined as activities necessary for the business operations of a health care entity but *do not* include marketing or fundraising activities.

"Withdrawal": You have the right to revoke this consent and withdraw your permission in writing regarding any future uses. Your revocation is effective when it is received by the entity that requested or disclosed your information. Your revocation or the expiration of the consent period is not effective with respect to any use or disclosure of your health information before the revocation is received or the expiration occurs. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records. Revocation or expiration of this consent may not apply to information provided to an insurer if state law provides the insurer the right to contest a claim under your policy.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal or state privacy law.

***[Note to recipient(s) of the information disclosed under this Consent: This information may have been disclosed to you from records protected by federal confidentiality (e.g. 42 CFR Part 2) or state privacy rules (e.g. Wisconsin Statute 51.30). If so, these rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted.***

**Limitations of this Form: If you want your health information shared for purposes other than for treatment, payment or health care operations, or if you want only a portion of your health information shared, you need to use a patient authorization form for limited disclosure of health information, instead of this form.** Also, this form cannot be used for disclosure of psychotherapy notes in any state or any Illinois mental health or developmental disability information and/or records, any of which require an additional authorization instead of this form. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.