Noble Community Clinics

MRN: _____
Office Use Only

# Permission to Accompany Adult Ward & Limited Release of Information

**Purpose:** To authorize a non-guardian individual to receive limited information about the adult ward, consistent with HIPAA rules permitting guardian-authorized disclosures to individuals involved in the ward's care (45 CFR 164.501(b)), and to allow the ward to attend appointments unaccompanied. Wisconsin Statutes Chapter 54 limits a guardian's decision-making authority but does not prohibit a ward from being physically present alone. Attendance is permitted without the guardian present; the guardian's authority applies to consent, not physical accompaniment.

**Scope of Permitted Information**: Information shared under this authorization is limited to scheduling details, visit logistics, after-visit summaries, and medication instructions. No diagnostic results, lab values, imaging reports, behavioral health records, or consent-requiring treatment information will be disclosed under this authorization.

This authorization does not grant the accompanying individual authority to provide informed consent for treatment. The legal guardian remains the sole party authorized to consent to any medical, behavioral health, dental, or other treatment decisions.

| **Patient (Ward) Name:** | **Date of Birth:** |
|---|---|
| | |

**Legal Guardian Name:**

**Accompanying Individual or Support Person Name:**

**Relationship to Patient (Ward):**

**Legal Guardian gives consent to Accompanying Individual to receive limited PHI**:
Verbal exchange with provider/care team for the following categories only - *check all that apply:*

☐**Appointment-Related Information:** appointment scheduling and reminders, notification of delays, cancellations, or rescheduling needs

☐**Coordination with Caregivers:** sharing the After Visit Summary (AVS) or after-care instructions, sharing medication administration instructions, explaining clinic requirements

☐**After-Visit Logistics & Instructions:** clarification of home-care instructions, when to return for follow-up, instructions on monitoring and when to call the clinic

☐**Guardian-specified limitations (please specify):**

**Duration:** This authorization expires on the "To" date listed below unless revoked earlier by the guardian.

**From:** _____**(MM/DD/YYYY)** **To:** _____**(MM/DD/YYYY)**

| **Legal Guardian signature:** | **Date & Time:** |
|---|---|
| | |

**Revocation Statement**: The guardian may revoke this authorization at any time by notifying Noble Community Clinics in writing. Revocation does not apply to information already disclosed.