UNIVERSITY of WISCONSIN-EAU CLAIRE
Student Health Service • 630 Hilltop Circle • Eau Claire, WI 54701
Phone: (715) 836-4311 • Fax: (715) 836-5979

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

1. Regarding Patient: **COMPLETE IN FULL**

Name – Last, First, MI		Maiden Name (if applicable)
Street Address		Telephone #
City	State	Zip Code
UW ID#	Birth Date	

2. I hereby authorize: **3. ☐ To Release to:** **☐ To Obtain from: (check one or both)**

Name – (health facility, physician…)				Name (insurance co, lawyer, physician, self…)	
Street Address				Street Address	
City	State	Zip		City	State Zip
Phone #	Fax #			Phone #	Fax #

4. INFORMATION TO BE RELEASED: (Check all applicable categories.)

☐ **Complete Copy of All Records** ☐ **Lab Reports** ☐ **Allergy Records**
☐ **Progress Notes** ☐ **Most recent GYN Health Records/Lab**
☐ **Immunization Records** ☐ **Clinic records pertaining to** _____
☐ **Other (specify)** _____

FOR THE FOLLOWING DATES: _____

In compliance with Wisconsin Statutes which require special permission to release otherwise privileged information, please release records pertaining to: (Check applicable conditions.)

☐ **Mental Health** ☐ **Developmental Disabilities** ☐ **Alcohol Treatment/Evaluation**
☐ **AIDS/AIDS-Related Illness** ☐ **Drug Treatment/Evaluation** ☐ **HIV Test Results**

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories.)

☐ **Continuity of Care** ☐ **Payment of Insurance Claim** ☐ **Academics**
☐ **Legal Investigation** ☐ **Personal** ☐ **Other** _____

6. **EXPIRATION:** This authorization will remain in effect for one (1) year from the date signed unless otherwise specified below.

☐ Expiration date prior to one year. Specify: _____

7. **ACKNOWLEDGEMENT OF UNDERSTANDING:** I understand that I have the following rights: **Refuse to sign** and still be assured treatment; **Right to inspect** and receive a copy of the disclosed material; and **Right of revocation** with written consent. **Re-disclosure:** I understand that information disclosed may be subject to disclosure by the recipient if they are not subject to federal health privacy laws.

8. Signature of patient _____ **Date**_____
(If signed by person other than patient, state relationship and authority to do so.)

9. NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without specific written consent of the patient or legal representative involved.

Office Use Only: Date and Time Processed:_____ **By:** _____ Rev. 03/14
(Staff Signature)