

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS**

 **1. Regarding Student:**

Name – Last, First, M.I.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UWW ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize: Two way written communication between 2 and 3 YES NO

 Two way verbal communication between 2 and 3 YES NO

**2. Records Released From 3. Records Release to**

|  |  |
| --- | --- |
| **Name**-(i.e. Physician, Counselor, School):**Street Address:****City: State: Zip Code:** | **Name**-(i.e. Physician, Counselor, School):**Street Address:City: State: Zip Code:** |
| **Phone #:** | **Fax #:** | **Phone #:** | **Fax #:** |

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

Complete Copy of all records Lab Reports Allergy Records Telephone Communication

Itemization/Coding X-ray Reports Counseling & Consultation Visits

Disability Records Psycho-educational Records

Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. PURPOSE OR NEED FOR DISCLOSURE:** (Check all applicable categories)
Disability Eligibility Personal Academic Services Legal Investigation

Payment to DVR or Insurance Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. This authorization will remain in effect until this request is processed unless you specify this authorization to be effective for an additional time period. Written consent is necessary to revoke this request.**

**Additional Time Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7. I authorize release of my medical/educational records in accordance with the specifications listed above. I understand I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.**

**8. Signature of the student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 further disclosure of this information without the specific written consent of the patient or legal representative involved.**