UNIVERSITY OF WISCONSIN WHITEWATER
Center for Students with Disabilities

University of Wisconsin-Whitewater
Center for Students with Disabilities
800 West Main Street
Andersen Library Room 2002
Whitewater, WI 53190
262.472.4711 (phone) 262.472.4865 (fax)
www.uww.edu/csd

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

1. Regarding Student:

Name – Last, First, M.I._____

UWW ID #_____ Birthdate_____ Phone #:_____

Street Address_____

City_____ State_____ Zip Code_____

2. Records Released From

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

3. Records Release to

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

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