University of Wisconsin – Whitewater
University Health & Counseling Services
800 W. Main Street
Whitewater, WI 53190
Phone: 262-472-1305 Fax: 262-472-1435

AUTHORIZATION FOR DISCLOSURE OF COUNSELING RECORDS

1. Regarding Patient COMPLETE IN FULL (See reverse side for instructions)

Name – Last, First, MI		
UW ID#	Birth-date	
Street Address		Telephone #
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

Name – (I.e. Health Facility, Physician)		
Street Address		
City	State	Zip Code
Phone #	Fax #	

3. Records Released to

Name – (Counseling Facility, Physician)		
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/verbal communication ☐ Itemization/Coding ☐ X-ray Reports/films
☐ Counseling & Consultation Visits ☐ Immunization Records
☐ Clinic records pertaining to outpatient treatment of: (Specify approximate date(s) or condition)_____
☐ 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 all 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)

☐ Further Medical Care ☐ Payment of Insurance Claim ☐ Application for Insurance
☐ Legal Investigation ☐ personal ☐ School Disability
☐ Academics ☐ Other: _____

*****PLEASE SEE REVERSE FOR FURTHER INFORMATION*****

6. **EXPIRATION DATE:** This authorization is valid for 1 year from the date of signature (or specific date up to 2 years, please list below) and covers records that were outlined in the dates above. Written consent is necessary to revoke this request.

☐ Additional time period. Specify: _____ ☐ None
☐ Include future records generated during the additional time period.

7. I authorize release of my medical records in accordance with the specification listed above. I understand that 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 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 the specific written consent of the patient or legal representative involved.

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

University Health & Counseling Services (UHCS) honor a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, UHCS may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. I also am aware that I may revoke this Authorization by notifying the medical records/health information department in writing.

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact University Health & Counseling Services (262) 472-1300 for further information.

Copying Fees. If you are requesting disclosure/release of medical information to other hospitals, clinics, or physicians for further medical care, or to yourself, no copying fees will be charged. You must pay for copies you request for other reasons.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact University Health & Counseling Services (262) 472-1300.