University of Wisconsin – Whitewater
University Health & Counseling Services
800 W. Main Street
Whitewater, WI 53190
Phone:262-472-1300(Health) 262-472-1305(Counseling)
Fax: 262-472-5608 (Health) 262-472-1435 (Counseling)

AUTHORIZATION FOR DISCLOSURE OF HEALTH/COUNSELING RECORDS

Patient Name:
Student ID:
Date of Birth:
Phone Number:
Address:

I hereby authorize: ☐ University Health Services and/or ☐ University Counseling Services to ☐ release information to and/or obtain from:
Name:
Company/Agency:
Address:
City, State, & Zip code:
Phone Number:
Fax:

☐ Records are needed for an appt on _____/ ☐ Records needed to schedule appt. ☐ P/U Copies – call me when ready

INFORMATION TO BE RELEASED:
☐ Complete Copy of All Medical Records ☐ Women's Clinic Visits ☐ Lab Reports
☐ Imaging ☐ Mental Health/Substance Use Summary Letter
☐ Complete Copy of Mental Health/Substance Use Records
☐ ADHD Evaluation/Psychoeducational Testing
☐ Telephone/Verbal Communication
☐ Other (specify) _____

PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)
☐ Further Medical Care ☐ Insurance/Workman's Comp ☐ School Disability
☐ Academics ☐ Personal ☐ Legal
☐ Other:_____

This authorization will remain in effect for one year after date of signature and includes future records generated after date of signing unless you specify otherwise. Written consent is necessary to revoke this request.
☐ Additional time period. Specify: _____
☐ Do not include future records generated after date of signing.

In accordance with the conditions listed above and below, I authorize the use and/or disclosure of my health information. I understand the information to be released selected above may include information regarding mental illness, developmental disabilities, alcohol or drug treatment, AIDS OR AIDS-related illness, sexually transmitted infection, and/or HIV test results, unless I limit the disclosure to exclude the following:

Signature of Patient: _____ **Date**: _____

(If signed by person other than patient, state relationship and authority to do so.)_____

ACKNOWLEDGEMENT OF UNDERSTANDING: **Right to refuse to sign**: I understand that I am under no obligation to sign this form and that the UHCS cannot refuse services based on my decision to sign this form. **Right to inspect**: I understand that I have a right to inspect and receive a copy of this form and the information being disclosed pursuant to it. I understand that records will be maintained for 10 years from the last date of contact. **Right of revocation**: I understand that I may revoke this authorization at any time by notifying the UHCS in writing. Revocation will be effective on the date notified except to the extent action has already been taken in reliance on the authorization. **Re-disclosure**: I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient if they are not subject to federal health privacy laws.

Release Date: _____ #Pgs. _____ Certified: Y N Via: Mail Fax Pick up Completed by Initials _____