UNIVERSITY of WISCONSIN - EAU CLAIRE

Student Health Service • Crest Wellness Center • 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.Records Released From: | **3. Records Released To:**

Records Released From		Records Released To	
Name (health facility, physician…) **UW- Eau Claire Student Health Service**		Name (insurance co, lawyer, physician, self…)	
Street Address **630 Hilltop Circle – Crest Wellness Center**		Street Address	
City **Eau Claire** State **WI** Zip **54701**		City State Zip	
Phone # **715-836-5360**	Fax # **715-836-5979**	Phone #	Fax #

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

- ☐ **Complete Copy of All Records**
- ☐ **Lab Reports**
- ☐ **Allergy Records**
- ☐ **Phone/Verbal Communication**
- ☐ **Progress Notes**
- ☐ **Recent GYN Health Records/Lab**
- ☐ **Appointment/Attendance Records**
- ☐ **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. This authorization will remain in effect until this request is processed. You may specify this authorization be in effect for an additional time period beyond the date records are sent (check box below and specify date). Written consent is necessary to revoke this request. I can refuse to sign this authorization and still be assured treatment.

   - ☐ Additional time period. Specify: ____
   - ☐ Include future records generated during the additional time period.

7. I authorize release of my medical records in accordance with the specifications listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent is as 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 specific written consent of the patient or legal representative involved.

Office Use Only: Date and Time Processed:________________________ **By:** ____________________________ Rev. 02/16
(Staff Signature)