Accessibility Resource Center

Authorization for Release of Records

The purpose of this release is for the UWM Accessibility Resource Center (ARC) staff to respond to inquiries from the person(s) named below, relating to the student's disability, their accommodations, and any services ARC may provide.

This release does not require ARC staff to disclose information deemed non-relevant to the student's disability, their accommodations (or any ARC services provided) or to take any specific actions on behalf of the student at the request of the person(s) named below.

This form may be completed online; however, when downloading the form to email as an attachment, please choose to **download with your changes**, or your information will be lost. The form may also be printed and completed by hand.

I ____________________ grant permission for my ARC records to be release to me or shared between me and:

My Access Specialist: ____________________________

From the UWM Accessibility Resource Center (ARC)
P.O. Box 413, Milwaukee, WI 53201
phone: (414) 229-6287; fax: (414) 229-2237
email: archelp@uwm.edu

AND/OR

Name: ____

Organization/Agency: ______________________________
(healthcare professional, self, clinician, parent)

Address:

City, State, Zip:

Phone: Email:

1. **Information to be released (check all that apply):**

   ☐ Disability Assessment Form/Report(s) verifying disability
   ☐ Accommodation Plan
   ☐ Psycho-educational/Neuropsychology/Medical Report(s)

2. **Purpose or need for disclosure (check all that apply):**

   ☐ Disability Eligibility Determination
   ☐ Advocacy/Liaison
   ☐ Personal/Self
   ☐ Student's Well-Being/Risk of Harm
   ☐ Other ________________________________

3. **Written consent is necessary to revoke this request.**

4. **I am aware that in-person pick up of information is the most secure form of communication. I am requesting my records/information be released or shared in the following way:**

   ☐ Records be picked up in-person (ID required)
   ☐ Send records via Fax to: ________________
   ☐ Do not send documents; release information through telephone/oral communication.
   ☐ Send records through the USPS to:

   ☐ Send records/communication electronically through email:

I authorize release of the above 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 form shall be valid as the original.

Signature of Student

Date

If signed by a person other than the student, state relationship and legal authority to do so.

Student is:

☐ Minor
☐ Incompetent/Incapacitated
☐ Disabled
☐ Deceased

Legal Authority:

☐ Parent of Minor
☐ Legal Guardian
☐ Next of kin of Deceased
☐ Other: _________________

For Office Use Only

Records picked up in person: ____________________________________

Records sent via USPS or fax: ____________________________________

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 individual involved.

Additional Information Regarding Release of Information

ARC recognizes a student's right to confidentiality of medical records as set forth by Wisconsin Statutes. Therefore, the student should be aware of the following guidelines prior to signing this form.

You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, ARC may not refuse services to you provided that you have met eligibility criteria.

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 information that the person(s)/organization(s) listed above have already made, in reliance on this authorization, before the time you revoke it. Your revocation must be made in writing and addressed to: UWM Accessibility Resource Center, P.O. Box 401, Milwaukee, WI 53201.

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

You have the right to inspect or copy the information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact ARC at (414) 229-6287.

If you are requesting disclosure/release of information in hardcopy to other agencies or to yourself, no copying fees will be charged.

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 information, unless one of the following applies:

- The student is incompetent.
- The student is disabled and cannot sign the form.
- The student is deceased (the surviving next of kin or legal representative must sign authorizations releasing records for the deceased).

If you are under the age of 18, your parent or guardian must sign this form for you, unless you are 14 years of age or older, and the records involve treatment for mental illness, alcoholism, or drug dependence.

For more information regarding who is authorized to sign this form, contact the UWM Accessibility Resource Center at (414)229-6287, P.O. Box 413, Milwaukee, WI 53201, archelp@uwm.edu.