UWM UNIVERSITY of WISCONSIN MILWAUKEE Accessibility Resource Center

"Promoting Access, Inclusion and Community"

Authorization for Release of Confidential Information

(complete in full, see reverse side for instructions)

1. Student Information:

Name- Last, First MI **Birth Date**

Mailing/Street Address **Telephone No.**

City State Zip **Student ID No**.

2. Records Released From:

Name – (ie. Health Facility, Physician)

Street Address

City State Zip

Telephone No. Fax No.

3. Records Released To:

Accessibility Resource Center
UW-Milwaukee
P.O. Box 413
Milwaukee, WI 53201
Phone: 414-229-6287
Fax: 414-229-2237

Information to be Released: (check applicable categories)

( ) All Clinic Records ( ) Educational Psychological Reports ( ) Telephone/Verbal Communications

( ) Clinic Records pertaining to inpatient/outpatient treatment of: (specify approximate date(s) of condition) _____

Other: (specify) _____

In compliance with Wisconsin Statues which require special permission to release otherwise privileged information, please release records pertaining to : (check all applicable conditions)

( ) Mental Health ( ) Developmental Disabilities ( ) Aids/Aids-Related Illness ( ) HIV Test Results

( ) Alcohol Treatment/Evaluation ( ) Drug Treatment/Evaluation

4. Purpose or Need for Disclosure: (check applicable categories)

( ) Disability Services Eligibility Determination ( ) Advocacy/Liaison ( ) Counseling ( ) Other _____

5. This authorization will remain in effect until: (see reverse side for further information) _____

6. I authorization release of my medical/educational records in accordance with he specification listed above. I understand written notification is necessary to cancel this request.

8. Signature of Student/Client _____ Date _____

(If signed by someone other than student, state relationship and authority to do so. See reverse side for signing authority)

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 CONFIDENTIAL INFORMATION

The Accessibility Resource Center 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 when requesting medical records. The numbers listed below correspond to the numbered sections on the authorization form.

6. Wisconsin Statutes recognize the need for informed consent. The patient may request multiple releases of the information stated on the authorization form. However, all releases based on this form are limited to records dated up to and including the patient's signature. A new authorization is necessary for release of information on care provided after the patient's signature, unless it is stated in the authorization to release "future records of a specific test, specified clinic appointment and/or admissions with the month and year identified."

7. Generally, all patients 18 years of age and older must sign for release of their records. Read the following to determine exceptions for patients older or younger than 18 years.

*****All patients 18 years of age and older must sign for release of their own medical records unless the following conditions apply:

a. The patient is incompetent.
b. The patient has a disability and cannot sign the form.
c. The patient is deceased. (The surviving spouse or legal representative must sign authorizations releasing records for the deceased patient.)

*****Patients less than 18 years of age must sign for release of their medical records when:

a. This patient is 14 years of age or older and the records involve treatment for mental illness, alcoholism or drug dependence.
b. The patient's record for release includes abortion procedures.

*****All persons signing for release of records, instead of the patient, must state their relationship to the patient and have available proof of legal authority to release the records.

Patient is: _____ Minor _____ Incompetent _____ Disabled _____Deceased

Legal Authority: _____Legal Guardian _____Parent of Minor _____Next of Kin Deceased

_____Health Care Power of Attorney