The Student Health and Wellness Center
2025 E. Newport Ave. NWQ Bldg D 7th Floor
Milwaukee, WI 53201

Phone: (414) 229-7429
Fax: (414) 229-4133

INFORMED CONSENT FOR DISCLOSURE OF MEDICAL HEALTH INFORMATION

Patient Name__________________ ________________
(first name middle initial last name)

Former Name ______________________________

Date of Birth ______________________________

1) I authorize the following Health Care Provider to disclose to the following Party:

____
Disclosing Party's Name (Health Care Provider)
____
Street Address
____
City State Zip

Phone: ___________________________________
Fax: ___________________________________

____
Receiving Party's Name
____
Street Address
____
City State Zip

Phone: ____________________________________
Fax: ____________________________________

These records are needed _______________

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3) The Following Information:

	Dates
☐ Annual GYN pelvic and pap	_______________
☐ Office Visit Notes	_______________
☐ Immunization History	_______________
☐ Lab Reports	_______________
☐ HIV related info/labs	_______________
☐ Other (specify)	_______________
☐ Verbal Discussion Only	_______________
☐ Itemized Bills: Dates from	_______ to _____
☐ Medication Record	_______________

4) Disclosure is being made for following purpose:

- ☐ Continuing Care
- ☐ Insurance / Claims
- ☐ Legal
- ☐ Personal Information
- ☐ Other (specify) _______________

5) Acknowledgement of Understanding (Initial each line):

___ I understand the expiration date of this authorization is ___________ (6 months from signature).
___ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.
___ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulation, though other privacy laws may apply.
___ By authorizing this use of disclosure of information, there will be no conditions placed on my health care or payment for health care.
___ I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it upon request.
___ **I understand that my request will be acted upon within 30 days.** If I am not provided access or information cannot be supplied, I understand I will be notified and have the right to request review of any denial of access other than those made in accordance with applicable law.
___ I understand that I may be required to pay the cost of preparing and mailing copies except for the purpose of treatment or payment.
___ **Patient is deceased** ___ **Patient does not have a spouse or domestic partner** **My Relationship to the patient:** _______________________

____
Patient/Legal Representative Signature

____
Date

SHAW Staff Only: Received, checked for completeness and logged by: ________________ ________________
(Date) (Account number))

Release Date _______________ # Pgs _____ Certified: Y N Via: Mail/email Fax Pick Up Intercampus Mail

Completed by Initials__________