



The Student Health and Wellness Center  
 University of Wisconsin-Milwaukee  
 2025 E. Newport Ave., NWQ Bldg D 8th Floor  
 Milwaukee, WI 53201

Phone: (414) 229-7429  
 Fax: (414) 229-3188

**INFORMED CONSENT FOR DISCLOSURE OF MENTAL HEALTH INFORMATION**

Patient Name \_\_\_\_\_  
 (first name middle initial last name)

Former Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**1) I authorize the following Health Care Provider:**

**2) To disclose to the following Party:**

Disclosing Party's Name (Health Care Provider) \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Fax: \_\_\_\_\_

Receiving Party's Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Fax: \_\_\_\_\_

**These records are needed for an appointment on \_\_\_\_\_.**  
 (Date of Appointment)

**3) The Following Information:**

**4) Disclosure is being made for following purpose:**

- Dates
- Psychotherapy Notes \_\_\_\_\_
  - Verbal Discussion Only \_\_\_\_\_
  - Medication Record \_\_\_\_\_
  - Letter re: my mental health condition \_\_\_\_\_

- Continuing Care
- Insurance / Claims
- Legal
- Personal Information
- Appeal for University Withdrawal
- 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 in the state of Wisconsin redisclosure is prohibited.
- \_\_\_ 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/Legal Representative Signature

\_\_\_\_\_  
 Date

SHAW Staff Only: Received and checked for completeness by: \_\_\_\_\_ (Date) \_\_\_\_\_ (Account Number)

Release Date \_\_\_\_\_ # Pgs \_\_\_\_\_ Certified: Y N Via: Mail Fax Pick Up Intercampus Mail

Completed by Initials \_\_\_\_\_

Rev 1/11; 6/08; 12/22