

INSTRUCTIONS FOR COMPLETING AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

Section 1: Regarding Patient

Please list your current address.

Section 2: Information Released From

Indicate the name of the organization to which information will be released from (select one per authorization) or write in the facility name and full address, phone and fax number.

If you want information to be released from University Health Services, please use the facility and full address, phone and fax number listed below:

University Health Services
333 East Campus Mall
Madison, WI 53715
Phone: 608-262-1676
Fax: 608-262-9160

Section 3: Information Released To

Indicate the specific person(s) and/or organization(s) who will be permitted to receive the information with the full mailing address, phone, and fax number.

Section 4: Information to be Released

Please select the applicable checkboxes identifying the information you would like to have released.

- Date Range – You are not required to, but you may enter a date range to further limit the information you want released. Please note that you must still select the applicable checkboxes of specific information you would like released.
- Complete Copy of Records – Selecting this option will authorize the release of your entire medical record. We recommend this selection for individuals who wish to have a copy of their health information for their personal health record.
- Specific information pertaining to – If you select this option, your description must be reasonably detailed. For example, “1/1/23 letter from Dr. Jane Doe.”
- Records requiring “special permission” – Please select the applicable checkboxes if you would like to release your mental health, substance use, developmental disabilities, or AIDS/HIV related information.

Section 6: Additional Types of Disclosure

Please note that while UHS providers frequently request that individuals select one or both options, it is your choice. If you require assistance or have questions, please contact the HIM Department at (608) 262-1676.

Section 7: Expiration Date

All authorizations are valid for one year from your signature date. However, you may choose to enter a specific expiration date to prolong the validity of this authorization.

Section 8: Signature of Patient or Authorized Representative

You may sign and date this authorization electronically. If you are familiar with using the electronic signature option, please refer to this helpful resource: <https://helpx.adobe.com/reader/using/sign-pdfs.html/>. If you are unable to sign electronically, please print the authorization and physically sign and date it.

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

1. Regarding Patient (COMPLETE IN FULL) (See reverse side for additional information regarding your request)

Name – Last, First, MI		
Street Address		Telephone #
City	State	Zip Code
WisCard ID#		Birthdate

2. Information Released From

Name – (i.e. Health Facility, Physician...)		
Street Address		
City	State	Zip Code
Phone #	Fax #	

3. Information Released To

Name – (i.e. Insurance Co., Lawyer, Physician, Self...)		
Street Address		
City	State	Zip Code
Phone #	Fax #	

4. Information To Be Released

Date Range: _____ to _____

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Complete Copy of Records | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Procedures | <input type="checkbox"/> Eating Disorder Office Visits |
| <input type="checkbox"/> Allergy Records | <input type="checkbox"/> Medication List | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Gynecology Office Visits |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Office Visits | <input type="checkbox"/> Radiology Images | <input type="checkbox"/> Sexual Health Office Visits |
| <input type="checkbox"/> Demographic Information | | | |
| <input type="checkbox"/> Specific information pertaining to: _____ | | | |

Federal and state laws require special permission to release certain information. Check the applicable boxes below to authorize release:

- | | | | |
|--|--|---|-----------------------------------|
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Alcohol or Drug Abuse | <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> AIDS/HIV |
|--|--|---|-----------------------------------|

5. Purpose or need for disclosure:

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Further Health Care | <input type="checkbox"/> Insurance | <input type="checkbox"/> Occupational Health | <input type="checkbox"/> Academics | <input type="checkbox"/> Victim Advocacy |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Personal/Self | <input type="checkbox"/> School Disability | <input type="checkbox"/> Worker's Compensation | |
| <input type="checkbox"/> Other (specify): _____ | | | | |

6. Additional types of disclosure:

- ☐ By checking this box, I authorize verbal communication (i.e. telephone calls) between the parties listed in Section 2 and Section 3.
- ☐ By checking this box, I permit the parties listed in Section 2 and Section 3 to share my confidential health information with each other.

7. Expiration date:

This authorization will remain in effect for one (1) year from the date of signature unless you specify otherwise. This authorization also covers the release of future records that are created after the date of signing unless otherwise specified below.

- ☐ Other expiration date: _____
- ☐ Do not include future records created after date of signing.

****PLEASE SEE NEXT PAGE FOR FURTHER INFORMATION****

By signing below, I authorize release of my health records in accordance with the specifications listed above and on the next page of this form. I understand there may be a charge for copies. A copy of this consent shall be valid as the original.

8. Signature of Patient/Representative: _____ **Date:** _____

(If signed by person other than patient, state your relationship to the patient and your legal authority below.)

Relationship: _____

- | | | | |
|------------------|--|--|--------------------------------------|
| Patient is: | <input type="checkbox"/> Minor | <input type="checkbox"/> Incompetent/Incapacitated | <input type="checkbox"/> Deceased |
| Legal Authority: | <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Spouse of Deceased | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Health Care Agent | <input type="checkbox"/> Personal Representative | |

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

University Health Services (UHS) honors a patient's right to confidentiality of health information as provided under federal and state law. Please read the following regarding guidelines and your rights before signing this authorization.

No Obligation to Sign:

You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, UHS health care providers may not refuse to provide you treatment or other health care services if you refuse to sign this form. UHS will not condition treatment, payment, enrollment, or benefit eligibility.

Revocation:

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 confidential health information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to: Health Information Management, 333 East Campus Mall, #8104, Madison, WI 53715-1381.

Re-release:

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and no longer be protected by state and federal privacy regulations. However, if the records disclosed pursuant to this authorization relate to substance use treatment, 42 CFR Part 2 prohibits the recipient from re-disclosing such records.

Right to Inspect:

You have the right to inspect or receive a copy of the confidential health information you have authorized to be used or disclosed, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact HIM by calling (608) 262-1676 for further information.

Copying Fees:

If you are requesting disclosure of health information to other hospitals, clinics, or physicians for further medical care, or to yourself, no copying fees will be charged. You must pay for copies you request for other reasons.

Signatures:

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 health information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact HIM by calling (608) 262-1676.

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 further disclosures of this information without specific consent of the patient or legal representative involved.