UNIVERSITY OF WISCONSIN-MADISON
UNIVERSITY HEALTH SERVICES
HIM (Medical Records)
333 East Campus Mall, Rm 8102
#8104
Madison, WI 53715-1381
Phone: (608) 262-1676 Fax: (608) 262-9160

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS

1. Regarding Patient ***COMPLETE IN FULL (See reverse side for further information)***

Name - Last, First, MI		
Street Address		Telephone #
City	State	Zip Code
UW ID#	Birthdate	

2. Records Released From

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

3. Records Released To

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

☐ Two Way Release (Release and obtain information from both parties listed).

☐ Records are needed for an appointment on _____/ ☐ Records needed to schedule appointment. ☐ Pick-up Copies

4. INFORMATION TO BE RELEASED: (Check all applicable categories)

☐ Complete Copy of Medical Records
☐ Women's Clinic Visits/Labs Only
☐ Allergy/Immunization Records
☐ X-ray Report/Images
☐ Lab Results
☐ Eating Disorder-Medical
☐ Mental Health Summary Letter
☐ Complete Copy of MH Records
☐ Telephone/Verbal Communication
☐ Other _____
☐ Psychiatry Transfer of Care
☐ Psychiatry Split Care Letter
☐ ADHD Evaluation/Psychoeducational Testing

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

☐ Mental Health
☐ Developmental Disabilities
☐ Alcohol Treatment/Evaluation
☐ Drug Treatment/Evaluation
☐ HIV Test Results
☐ Aids/Aids-Related Illness

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

☐ Further Health Care
☐ Legal
☐ Academics
☐ Insurance/Work Comp
☐ Personal/Self
☐ Other:_____
☐ Occupational Health
☐ School Disability

*****PLEASE SEE REVERSE FOR FURTHER INFORMATION*****

6. This authorization will remain in effect for one year after date of signature unless you specify otherwise and includes future records generated after date of signing unless otherwise specified. Written consent is necessary to revoke this request.

☐ Other time period. Specify: _____
☐ Do not include future records generated after date of signing.

7. I authorize release of my health records in accordance with the specification listed above. I understand that I have a right to receive a copy of this form upon request. A copy of this consent shall be valid as the original.

8. Signature of patient_____ **Date**_____
(If signed by person other than patient, state relationship and authority to do so.)

Internal Use Only: _____ SCAN ONLY Release Date: _____ Via: Mail Fax Completed by Initials _____

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT HEALTH INFORMATION

University Health Services (UHS) honor a patient's right to confidentiality of health information as provided under federal and state law. Please read the following guidelines 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 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: HIM (Medical Records), 333 East Campus Mall, #8104, Madison, WI 53715-1381.You must also revoke in writing to the facility/MR department releasing my information.

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

Right to Inspect. You have the right to inspect or copy the health information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact HIM (Medical Records) at (608)262-1676 for further information.

Copying Fees. If you are requesting disclosure/release 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.

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 the specific consent of the patient or legal representative involved.

Signatures. 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 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 (Medical Records) at 333 East Campus Mall, #8104, Madison, WI 53715-1381 or call (608)262-1676.