

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

STUDENT HEALTH CENTER, University of Wisconsin Oshkosh
777 Algoma Blvd., Radford Hall, Oshkosh, WI 54901
Medical Records PHONE: 920-424-0835; FAX: 920-424-1769

1. _____
Name of Patient Phone Number Birth Date

Street Address City, State, Zip SS#

2. **AUTHORIZES:**

3. **RELEASE HEALTH INFORMATION TO:**

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip

4. **INFORMATION TO BE RELEASED:**

- ___ Medical History and Physical
- ___ Progress Notes
- ___ Mental Health
- ___ Sexually Transmitted Diseases
- ___ Alcoholism and Drug Abuse
- ___ Other (Specify): _____
- ___ Immunizations
- ___ Allergy Records
- ___ X-ray Reports and Laboratory Reports
- ___ Developmental Disabilities
- ___ HIV/AIDS
- ___ TB Skin Test Results

For the following date(s): _____

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

- ___ Further Medical Care
- ___ Insurance Eligibility/Benefits
- ___ Legal Investigation or Action
- ___ Other (Specify): _____
- ___ Personal
- ___ Education/School
- ___ Employment

6. Disclosure may be in the form of photocopies, verbal or fax.

7. **Your Rights with Respect to This Authorization**

- **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, I must be provided with a signed copy of the form.
- **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Refusing to sign this authorization may result in consequences from the entity requesting the information.
- **Right to Withdraw This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Director of the Student Health Center.

8. **Expiration Date:** This authorization expires one year from date signed.

The information released may be subject to re-disclosure by the receiving entity. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

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

- Patient is:** Minor Incompetent Disabled Deceased
Legal Authority: Custodial Parent Legal Guardian Executor or Estate of Deceased
 Power of Attorney for Health Care Authorized Legal Representative