University of Wisconsin Oshkosh Counseling Center
Oshkosh, Fox Cities & Fond du Lac Campuses
800 Algoma Boulevard
Oshkosh, WI 54901

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH

1. Regarding Student and/or Patient *COMPLETE IN FULL (See reverse side for more information)*

Name – Last, First, MI		
Street Address		Cell Phone #
City	State	Zip Code
UW ID#	Birthdate	Home Campus: ☐ Oshkosh ☐ Fox Valley ☐ Fond du Lac

2. Records Released

From:

Name – (i.e. Health Facility, Physician ...)		
University of Wisconsin Oshkosh Counseling Center		
Street Address		
800 Algoma Blvd		
City	State	Zip Code
Oshkosh	WI	54901
Telephone #	Fax #H	
920-424-2061	920-424-1066	

To:

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

☐ Two Way Release (Release and obtain information from all parties listed). ☐ Dates of service _____
☐ Records are needed for an appointment on _____/ ☐ Records needed to schedule appointment.

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

- ☐ **Alcohol & Other Drug Abuse (AODA) Assessment**
- ☐ **Diagnosis**
- ☐ **Secondary Health Records**
- ☐ **Full Case File**
- ☐ **Identity & Presence in Treatment**
- ☐ **Counseling Summary**
- ☐ **Legal Status/Court Records**
- ☐ **Medications/Medication Profile**
- ☐ **Mental Health Assessment**
- ☐ **Counseling Updates**
- ☐ **Psychiatric Evaluation**
- ☐ **Treatment Plan**
- ☐ **Other (specify):** _____

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

- ☐ Mental Health
- ☐ AODA Treatment/Evaluation
- ☐ HIV Test Results
- ☐ Developmental Disabilities
- ☐ Academic
- ☐ AIDS/AIDS-Related Illness

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

- ☐ Case Coordination
- ☐ Advocacy
- ☐ Student Requested
- ☐ Consultation
- ☐ Treatment
- ☐ Referral
- ☐ Other: _____

5. 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 signature.

6. 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.

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

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF STUDENT/ CLIENT MENTAL HEALTH INFORMATION

The University of Wisconsin Oshkosh honors a patient's right to confidentiality of mental 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, UWO Counseling Center may not refuse to provide you treatment if you refuse to sign this form. UWO will not condition treatment, payment, and 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: University of Wisconsin Oshkosh, Counseling Center, 800 Algoma Blvd., Oshkosh, WI 54901. **Re-release.** If the person(s) and/or organization(s) authorized by this form to receive your mental health information are not mental health care providers or other people who are subject to federal health privacy laws, the mental 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 the University of Wisconsin Oshkosh Counseling Center at (920) 424-2061 for more information.

Request for Records. You have a right to a copy of your mental health records. To obtain a copy of your records, you must provide your request in writing. The Counseling Center can also provide you a treatment summary letter in lieu of the full copy of your records if desired. The Counseling Center will provide you a copy within ten business days of your request. If you are requesting disclosure/release of mental 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 the University of Wisconsin Oshkosh Counseling Center at (920) 424-2061.