AUTHORIZATION TO RELEASE MEDICAL RECORDS

STUDENT HEALTH CENTER, University of Wisconsin Oshkosh
777 Algoma Blvd., Radford Hall, Oshkosh, WI 54901
Medical Records PHONE: 920-424-2092; FAX: 920-424-1769

Name of Patient	Phone Number	Birth Date
Street Address	City, State, Zip	Student ID#

RECORDS RELEASED FROM:	**RECORDS RELEASED TO:**
Name of Health Care Provider /Other	Name of Health Care Provider /Other
Street Address	Street Address
City, State, Zip	City, State, Zip

INFORMATION TO BE RELEASED: (*Special Permission)*

_____ Medical History and Physical
_____ Progress Notes
_____ ***Mental Health***
_____ ***Sexually Transmitted Diseases***
_____ ***Alcoholism and Drug Abuse***
_____ Immunizations
_____ Allergy Records
_____ X-ray Reports and Laboratory Reports
_____ ***Developmental Disabilities***
_____ ***HIV/AIDS***

_____ Other (Specify): _____

PURPOSE OF DISCLOSURE:

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

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

MY RIGHTS:

- **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, I may request 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 revoke this authorization. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. To obtain information on how to revoke this authorization I may contact the Medical Records clerk or the Director of the Student Health Center. Upon receipt of a completed revocation form, UW Oshkosh Student Health will submit the revocation to any and all entities previously authorized to receive my Protected Health Information.

Expiration Date: This authorization expires one year from date signed or **Specified Date: _____**

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.

Signature: _____ Date: _____
(Patient, guardian, or authorized representative)