Counseling and Health Center
2420 Nicolet Drive SS 1400
Green Bay, WI 54311-7001
Phone (920) 465-2380
Fax (920) 465-2708

Authorization for Release of Counseling or Health Records

1. REGARDING PATIENT ***COMPLETE IN FULL***

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

2. I HEREBY REQUEST AND AUTHORIZE: UNIVERSITY OF WISCONSIN—GREEN BAY COUNSELING AND HEALTH CENTER

☐ **TO DISCLOSE INFORMATION TO:** ☐ **TO RECEIVE INFORMATION FROM:** ☐ **TO EXCHANGE INFORMATION WITH:**

_____

Person / Organization **Phone #** **Fax #**

_____

Address **City** **State** **ZIP**

3. DISCLOSE BY: ☐ Fax(to number above) ☐ Mail(to address above) ☐ Will Pick Up ☐ Verbal Contact

4. DATES OF SERVICE TO INCLUDE: _____

5. MEDICAL INFORMATION TO BE RELEASED: (check information requesting)

- ☐ Nursing Visit Notes
- ☐ GYN exam medical notes AND pap smear/cytology report
- ☐ TB test results
- ☐ Immunization Records
- ☐ Medical Exam Reports
- ☐ Lab reports
- ☐ X-ray reports/films
- ☐ Other _____

COUNSELING/PSYCHIATRIC INFORMATION TO BE RELEASED:(check information requesting)

- ☐ Counseling Visit Notes
- ☐ Counseling Initial Evaluation
- ☐ Discharge Summary
- ☐ Dates of All Counseling or Testing Sessions
- ☐ Current condition or condition at last session
- ☐ Psychiatric Visit Notes
- ☐ Psychiatric Initial Evaluation
- ☐ Other_____

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

- ☐ Mental Health
- ☐ Developmental disabilities
- ☐ Alcohol treatment/evaluation
- ☐ AIDS/AIDS related illness
- ☐ Drug treatment/evaluation
- ☐ HIV test results

6. PURPOSE OR NEED FOR DISCLOSURE: (check all applicable categories)

- ☐ Further medical or mental health care
- ☐ Personal
- ☐ Insurance/claims
- ☐ Legal
- ☐ Other
- ☐ Academics
- ☐ School Disability

7. This authorization will remain in effect until this request is processed unless you specify the authorization will be effective for an additional time period. Written consent is necessary to revoke this request.
   ☐ One year from signature: ☐ Additional time period. Specify: _____ ☐ None
   ☐ Include future records generated during the additional time period
8. I authorize release of my health records in accordance with the specifications listed above. I understand that I have the right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as original.
9. Signature of Patient _____ Date _____
   (If signed by a person other than patient, state relationship and authority to do so.)

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

REDISCLOSURE: I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Refuse to Sign this Authorization: I understand that I am under no obligation to sign this form. The person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, or enrollment in a health plan or eligibility for the health care benefits on my decision to sign this authorization.

Right to Receive a Copy of this Authorization: I understand that if I agree to sign this authorization, I have the right to inspect or receive a copy of the information disclosed with certain exceptions provided under state and federal law. If you would like to receive a copy or inspect your records contact the Counseling and Health Center at (920) 465-2380.

Right to Withdraw this Authorization: I understand written notification is necessary to cancel this authorization. I realize that if I cancel this authorization, it will not affect uses and/or disclosures of my information that have already occurred based upon my authorization. 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: Counseling and Health Center, 2420 Nicolet Dr., SS1400, Green Bay, WI 54311.

Signatures: Generally, if you are 18 years of age or older, you alone are permitted to sign a form to authorize the disclosure of your records. If you are under age 18, your parent or guardian must sign this form for you. However there are situations in which this rule does not apply. For information on who is authorized to sign this form contact the Counseling and Health Center at (920)465-2380.

Note to the patient: If information is released under Wisconsin Statute 51 – State Alcohol, Drug Abuse, Developmental Disability and Mental Health Act, the patient has a right to inspect and receive a copy of the material to be disclosed as required under ss. HFS Confidentiality of Treatment Records 92.05 and 92.06.

This disclosed information is protected under Federal law titled Standards for Privacy of Individually Identifiable Health Information 45 CFR Parts 160 & 164 and by Wisconsin Statute 146.82 Confidentiality of Patient Health Care Records, 51.30 Mental Health Act, and 146.83 Access to Patient Health Care Records. Federal regulations prohibit you from making any further disclosure of this information without specific authorization for the release of medical or other information is not sufficient for this purpose.

Note To Recipient Of Information: This information has been disclosed to you from confidential records, 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.

FOR OFFICE USE:

Information released date: _____ Via: Mail Fax Pick up Verbal Completed by initials: _____