



University of Wisconsin
Hospital and Clinics

600 Highland Ave. Madison, WI 53792

Mail to: Health Information Management
8501 Excelsior Drive
Madison, WI 53717

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. Patient Information

Name- Last, First, MI			
Street Address	City	State	Zip
Medical Record Number	Birthdate	Phone Number	

2a. MEDICAL RECORDS to be Disclosed (Please check only one box)

Comprehensive overview of entire chart (contains all discharge summaries, all outpatient notes, all pathology reports, and all clinic summaries, x-ray reports, EKG and lab reports). **Note: Radiology Images/Films must be requested separately below and will be mailed from the Medical Imaging department. See section 2b.**

Records pertaining to: _____ Other (describe): _____
(dates or conditions)

Complete copy of official medical record

Format for Records: Paper **OR** DVD (requires PDF viewer) **Please check only one box. If both formats are needed, submit a separate authorization for the other format. Please note, if a format is not selected, records will be in paper format**

2b. RADIOLOGY IMAGES/FILMS to be Disclosed (Please check only one box):

All radiology films Films pertaining to: _____
(dates and/or studies)

3. Disclosed By: University of WI Hospital & Clinics (or):

Name – (e.g. Health Facility, Physician...)		
Address		
City	State	Zip Code

4. Disclosed To:

Name – (e.g. Insurance Company, Lawyer, Physician, Patient...)		
Address		
City	State	Zip Code

5. Purpose or need for disclosure. (Please check all applicable categories)

- further medical care payment of insurance claim legal investigation
 application for insurance vocational rehabilitation patient use
 disability determination other _____

6. This authorization will remain in effect until the above disclosure(s) have been completed unless you specify that this authorization will not be effective for an additional time period. (NOTE that if you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.)

Other specific expiration date or event (specify): _____ (mm/dd/yy)

****PLEASE SEE NEXT PAGE FOR FURTHER INFORMATION****

In accordance with the conditions listed above and on the next page of this form, I authorize the use and/or disclosure of my medical information. I understand that there may be a charge for copies. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and/or HIV test results, with the following exception(s):

Signature of Patient

If signed by person other than patient, state relationship and authority to do so.
(See next page for information about signatures.)

Relationship: _____

Patient is: Minor Incompetent/Incapacitated Deceased

Legal Authority: Legal Guardian Parent of Minor Spouse of Deceased

Health Care Agent _____

Personal Representative/Domestic Partner of Deceased

Other _____

Date: _____

UWHC Release Documentation

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

UW Health Care providers (including providers with the University of Wisconsin Hospital and Clinics, the University of Wisconsin Medical Foundation, and certain units of the University of Wisconsin-Madison) honor a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Federal HIPAA Privacy Rules: These federal rules indicate when your protected health information may be used or disclosed without your authorization. Please see our Notice of Privacy Practices for additional information.

Wisconsin Right to Privacy: Under Wisconsin law, you have the right to be free from unreasonable invasions of privacy. Wisconsin's "Right of Privacy" statute prevents individuals from using your name, portrait, or picture for advertising or trade purposes without first obtaining your written 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, UW Health Care Providers may not refuse to provide you treatment or other health care services if you refuse to sign this form.

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 medical 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: UWHC Health Information Management, 8501 Excelsior Drive, Madison, WI 53717.

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

Right to Inspect: You have the right to inspect or copy the medical 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 patient accounting or medical records department of the UW Health facility (hospital or clinic) where you have received care.

Copying Fees: If you are requesting disclosure/release of medical information to other hospitals, clinics, or physicians for further medical care, no copying fees will be charged. You must pay for copies you request for other purposes.

Multiple Formats for Release of Medical Records (Paper vs DVD): You may request records in either paper format or on DVD, however only one format will be released per authorization. You will be asked to submit a separate request for each format if both formats are desired (and may be charged for each request).

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 medical 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 UWHC Health Information Management, 8501 Excelsior Drive, Madison, WI 53717, (608) 263-6030, Option 3.