LAWRENCE UNIVERSITY
APPLETON, WISCONSIN

Authorization for Release of Health Records

Landis Health Center Lawrence University
711 E. Boldt Way SPC 3
Appleton, WI 54911
Phone (920)832-6574
Fax (920)832-7488

1. Patient Information:

Name-Last, First, MI		
LU ID #	**Date of Birth**	**Telephone #**
Street Address		
City	**State**	**Zip Code/Country**

2. Records Released From:

Name		
Street Address		
City	**State**	**Zip Code**
Phone #	**Fax #**	

3. Release Records To:

Name		
Street Address		
City	**State**	**Zip Code**
Phone #	**Fax #**	

☐ Two Way Release (Release and obtain information from both parties listed).

4. Information to be Released: (Check all applicable categories)

☐ Medical Records ☐ Immunization Record ☐ Allergy shot records
☐ Lab results ☐ Mental Health Record ☐ Psychiatry Evaluation
☐ Eating Disorder-Medical ☐ HIV tests ☐ Other:_____

5. Purpose or Need for Disclosure: (Check all applicable categories)

☐ Further Health Care ☐ Academics ☐ Personal/Self
☐ Referral ☐ Legal ☐ Other:_____

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

6. 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 signing.**

7. 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.

8. Signature of patient_____Date _____
(If signed by person other than patient, state relationship and authority to do so.)

I understand that my records are protected under Federal and State confidentiality laws and regulations and may not be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except for the extent that action has been taken in reliance on it and that in any event, this consent expires automatically as described below.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to inspect or copy the health information to be used or disclose: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Counseling Services. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under HSS 92.05 and 92.06 of the Wisconsin Administrative Code.

Right to receive copy of this authorization: I understand that if I agree to sign his authorization, which I am not required to do so, I must be provided with a signed copy of the form.

Right to refuse 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 whom I am authorizing to use/and/or disclose my information may not condition treatment based on my decision to sign this authorization.

Right to withdraw this authorization: I understand that 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 Counseling Services. I am aware that my withdrawal will not be effective as to uses and/or disclosers of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

Disclosure to another health care provider: Treatment facilities may release limited information without written consent to a health care provider under emergency situations. This information may be released without consent under HSS 51.30.