WISCONSIN LUTHERAN COLLEGE

HEALTH SERVICES

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

INDIVIDUAL/PATIENT:

Name: _____ Date of Birth: _____ Student ID#: _____

AUTHORIZES THE DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

Information will only be used/disclosed to coordinate care with the appropriate people/offices.

WLC Campus Office/Personnel (Check all that apply):

___ Academics / Professors ___ Athletics ___ Campus Employer ___ Campus Ministry ___ Counseling
___ Residence Life ___ Student Success ___ Support & Disabilities ___ VP Student Life ___ Other: _____

Community Member/Provider (Check all that apply):

___ Emergency Contact ___ Healthcare Provider ___ Public Health ___ Counselor ___ Other: _____
Name: _____ Organization/Agency: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____ Fax: _____

INFORMATION DISCLOSED BY:

Wisconsin Lutheran College Health Services - 8800 W. Bluemound Road, Milwaukee, WI 53207
_X_ Indicates a reciprocal release of information

INFORMATION TO BE USED OR DISCLOSED (Check all that apply):

The following is a specific description of health information I authorize to be used and/or disclosed:
___ Entire Medical Record *(*if checked, do not select other records*)
___ COVID-19 / Influenza ___ General Health Information ___ Health History / Physical ___ Immunization Records ___ Lab Test / X-Ray
___ Medications ___ Medical Diagnosis ___ Treatment Plan ___ Personal Health Insurance ___ Radiology
___ Other: _____

Pursuant to Wisconsin law requires, I specifically request the disclosure of the following records: (check all that apply)
___ Alcohol / Drug Abuse ___ Developmental Disabilities ___ Mental/Behavioral Health ___ STI / HIV test results
___ Other:_____

PURPOSE OF DISCLOSURE:

___ Coordinating Care ___ Insurance Billing ___ Individual's Request ___ Further Medical Care ___ Other:_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization.
Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Health Services may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.
Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to *Health Services*. I am aware that my withdrawal will not be effective until received by Health Services and will not be effective regarding the uses and/or disclosures of my health information that Health Services has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) 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 Health Services**.**

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.
EXPIRATION DATE: By signing this authorization, I am confirming that it accurately reflects my wishes. This authorization will be in effect for
___ One (1) year ___ Remainder of my enrollment at WLC unless I revoke it in writing ___ Other: _____

SIGNATURE: _____ **DATE:** _____
(if signed by other than individual, state relationship with signature)