Student Accessibility Services

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION TO UW-COLLEGES STUDENT ACCESSIBILITY SERVICES

STUDENT NAME: ____ CAMPUS: ______________

STREET ADDRESS: ____

CITY: ________________________________ STATE: ________________ ZIP: _________________

PHONE: (   ) ________________ BIRTHDATE: __________________

I hereby authorize the release of the following information (check all that apply):

- ☐ Educational Records
- ☐ Medical Records - All records, writings, reports, case notes, treatment plans, evaluations, and summaries relating to my physical condition or treatment.
- ☐ Psychological Records-All records, writings, reports, case notes, treatment plans, evaluations, and summaries relating to my psychological condition or treatment
- ☐ Conversation/Correspondence Regarding Student
- ☐ Other (specify):_______________________________

Information from:

Name of Doctor/Practitioner: ____

Name of Clinic/School: ____

Mailing Address: ____

City: _________________________________ State: _______________ ZIP: ______________

Phone: (   ) _________________ FAX: (   ) ______________

The above checked information may be released to:

Kristin Hoffmann, Director of Student Accessibility Services
1500 North University Drive, A122
Waukesha, WI 53188
VOICE (262) 524-3957
FAX (262)521-1026
kristin.hoffmann@uwc.edu

I understand that I can submit a written statement revoking or changing this release form at any time. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under SS. HSS 92.05 and 92.06, and Wis. Stats. Sec.146.83. This release expires one year from the date it is signed. (Copies of this release are as valid as the original.)

Student Signature: ____ Date: _________________