G:\COUNSEL\ESA\MEDREL#2.FRM **SAMPLE**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To: _____
_____
_____
_____

Attn: Medical Records Department

I hereby authorize disclosure by my health care provider(s) to _____ at _____ of all information, including all personnel and medical records, concerning my ability to perform job-related functions for the University with or without reasonable accommodation. I authorize _____ to speak directly to my health care provider(s). I further authorize my health care provider(s) to provide professional opinions regarding these records and regarding my ability to perform job-related functions. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining my authorization or my signing this authorization. I further understand that by signing this release, I am authorizing my health care provider(s) and the University to access information that might not otherwise be available to them. This release is valid for one year from the date of my signature below unless I exercise my right to revoke this release in writing before the expiration date by so informing the University in writing. Written revocation of this agreement will not affect disclosures of information that have already been made in reliance on this release, before the time I revoke it.

I understand that information disclosed pursuant to this release may no longer be protected by federal privacy laws, and may be subject to re-disclosure by the recipient without your prior permission. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illnesses, and/or HIV test results, with the following exceptions: _____.

Dated at _____, Wisconsin, this ____ day of _____, 200 .

_____

DOB: _____

SSN: _____