UW Health
University of Wisconsin Hospital and Clinics
600 Highland Avenue
Madison, WI 53792

Health Information Services
8501 Excelsior Drive
Madison, WI 53717

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. Patient Information

Name - Last, First, MI		
Street Address		
City	State	Zip Code
Medical Record Number (Brown Card Number)	Birthdate	Phone No.

2. Information 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, EKG and lab reports)
- ☐ Records pertaining to: _____ date(s) or condition(s)
- ☐ Complete copy of official medical record
- ■ Other (describe): PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

3. Disclosed By: ☐ University of Wisconsin Hospital and Clinics (or)

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

4. Disclosed To:

Name - (e.g. Insurance Company, Lawyer, Physician, Patient . . .)		
RECORDS DEPOSITION SERVICE, INC.		
Address		
PO BOX 5054		
City	State	Zip Code
SOUTHFIELD, MI, 48086-5054		

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

- ☐ further medical care
- ☐ application for insurance
- ☐ disability determination
- ☐ payment of insurance claim
- ☐ vocational rehabilitation
- ■ other PRE TRIAL DISCOVERY
- ☐ legal investigation
- ☐ patient use

6. This authorization will remain in effect until the above disclosure(s) have been completed unless you specify that this authorization will be effective for an additional time period. *(To specify an additional time period, please check one of the boxes below. 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: _____ (mm/dd/yy)
- ☐ Other expiration event (specify): _____

PLEASE SEE REVERSE FOR FURTHER INFORMATION

In accordance with the conditions listed above and on the reverse side 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 _____ **Date** _____

If signed by person other than patient, state relationship and authority to do so.
(See reverse 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 of Deceased ☐ Other _____

UWHC Release Documentation