LAWRENCE UNIVERSITY

WELLNESS SERVICES CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, (student name) DOB: _____ (enter date of birth)

authorize Lawrence University Counseling Services: ☐ TO DISCLOSE TO ☐ TO OBTAIN FROM

(Name of Person and/or Organization) (Address/City/State/Zip)

THE FOLLOWING INFORMATION (check all that apply)

☐ Mental Health Records ☐ Initial Evaluation ☐ Confirmation Letter to Referral Source

☐ Medical Records ☐ Progress Notes ☐ Psychological/Psychiatrist Evaluation

☐ Discharge Summary ☐ Academic Records ☐ Other (Please specifiy): Click here to enter text.

VIA: ☐ Verbal ☐ Written ☐ Fax ☐ Email

FOR THE PURPOSE OF:

☐ Facilitating family/significant other involvement ☐ Facilitating referral

☐ Establishing diagnosis and treatment plan ☐ Coordination of treatment

☐ Facilitate academic and/or administrative decisions ☐ Other (Please specify): Click here to enter text.

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 this 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.

Expiration date: This authorization is good until or for one year from the date signed, and includes treatment records created after the date of signature. I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Client:_____ **Date:**

Witness:_____ **Date:**

Please send records to: Lawrence University Counseling Services, SPC 3, 711 E. Boldt Way, Appleton WI 54911 // 920-832-6574 (phone) 920-832-7488 (fax)