Community Outreach Wisconsin
122 East Olin Avenue, Suite 255, Madison, Wisconsin 53713
Phone: (608) 265-9440 | Fax: (608) 263-4681
Website: http://cow.waisman.wisc.edu

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: ___/___/____ Social Security #: _____-_____-_____

Address: _____ City, State, Zip: _____

Please note: When using a copy of this release form in connection with a request for information from one of the persons/ organizations/agencies listed, the identifying information that does not pertain to a particular request will be blocked out to protect the confidential nature of this information.

I authorize Waisman Center Community Outreach Wisconsin to disclose and receive information and records to and/or from the persons/organizations/agencies listed below for the purpose of sharing information relevant to the healthcare and wellness needs of the consumer. Disclosure under this release includes access to records, permission to obtain copies of records, and verbal discussion of information between agency staff and individual service providers.

Name of Individual/Agency	Provider or Facility Address	City, State, Zip	Phone #/Fax # (Include area code)
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All TYPES OF RECORDS ARE AUTHORIZED: ☐ **MEDICAL, PSYCHOLOGICAL and All Others:**

***SPECIFIC INFORMATION AUTHORIZED*:** (select one or more as appropriate)

☐ **Assessments** ☐ **Progress Notes** ☐ **Laboratory Test Results: _____**

☐ **Diagnostic Impression** ☐ **Discharge Summary** ☐ **Treatment Plans** ☐ **Medications**

☐ **Treatment Summary** ☐ **Psychiatric/Psychological Evaluation and/or Treatment**

☐ **Other: (please describe)** _____

Send to: Waisman Center Community Outreach Wisconsin
122 E. Olin Ave, Ste. 255
Madison, WI 53713

A photocopy of this authorization has the same effect as the original.

I understand that:

- I may cancel this authorization at any time by submitting a ***written*** request to the Waisman COW Program. However, information sent prior to withdrawal of consent cannot be recalled.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- I have the right to inspect and receive a copy of the disclosed information.
- 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.

I hereby consent to the release of information as described above.

Signature of Consumer: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Legal Guardian (if applicable): _____ Date: _____