State of Wisconsin
Department of Workforce Development
Equal Rights Division

Medical Release Authorization

ERD Case Number: CR_____

Sections 111.35 & 101.22 Wisconsin Statutes allow the Equal Rights Division to secure medical information to investigate a complaint. Completion of this authorization is voluntary.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Physician or Medical Facility Name	
Physician or Medical Facility Street Address	
Physician or Medical Facility City	
Physician or Medical Facility State	Physician or Medical Facility Zip Code

I give permission to the above named physician or medical facility to release information regarding my physical and/or mental condition from (date) _____ to (date) _____ to Equal Rights Officer _____. The Equal Rights Officer will use this information to assist in the investigation of my complaint that I filed with the Equal Rights Division of the Department of Workforce Development.

I authorize the physician or medical facility to pre-bill me for the information released to the Equal Rights Division. I have been informed that I may revoke this authorization in writing at any time.

This authorization will be valid for six (6) months from the date signed below.

Name of Patient	Patient Date of Birth
Authorizing Signature	Date Signed
Patient Street Address	
Patient City	
Patient State	Patient Zip Code

Please mail completed authorization form to the Equal Rights Division address checked below.

☐ PO Box 8928 Madison, WI 53708	☐ 819 N. 6th St., #723 Milwaukee, WI 53203
☐ 221 W Madison St Ste 218 Eau Claire, WI 54703	☐ 1802 Appleton Road Menasha, WI 54952