CHILD SUPPORT AGENCY

711 NORTH BRIDGE STREET
CHIPPEWA FALLS, WI 54729
Phone: 715-726-7750 Fax: 715-726-7945
Website: http://www.chippewacountywi.gov Email: childsupport@chippewacountywi.gov

Request for Medical Status

Instructions: Complete the information below based on the most recent date of treatment and return this form to the Chippewa County Child Support Agency.

This request for information is being made in accordance with 42 U.S.C. 654, which requires that each state use all available sources of information to locate absent parents or alleged absent parents. This information will be used solely to enforce Wisconsin Child Support laws. You are authorized to release this information by s. 49.22 (2m). Wis. Stats A covered entity under the Health Insurance Portability and Accountability Act (HIPPA) may disclose protected health information to the extent that disclosure is required by law or to an agency performing a government regulatory program [45 C.F.R. s. 164.512(a) & (d)(1)(iii)].

The information on this form may be utilized by the patient in a court proceeding to validate a medical or health condition limiting his or her ability to work for purposes of paying child support obligations.

Patient Name: _____ Date of Birth: _____

Medical Provider Facility: _____

Address: _____

_____ Phone: _____

Date of Treatment: _____

Diagnosis / Treatment Provided: _____

_____

Is patient complying with recommended treatment ? Yes No

If no, what is the patient failing to do ? _____

Based on examination and treatment described above, indicate which option describes the patient's current ability to work and provide other information requested for that selection.

☐ **NO LONGER ABLE TO WORK** as of _____(date)

☐ **TEMPORARILY UNABLE TO WORK** as of _____(date)

AND remains unable to work until patient is reevaluated on _____(date)

OR until _____

☐ **ABLE TO RETURN TO WORK WITH RESTRICTIONS** as of _____(date)

Restrictions: _____

_____

☐ **ABLE TO RETURN TO WORK WITHOUT RESTRICTIONS** on _____(date)

Treatment Provider's Printed or Stamped Name: _____

Treatment Provider's Signature: _____ Date: _____