CHIPPEWA COUNTY DEPARTMENT OF HUMAN SERVICES

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

CLIENT NAME:	DATE OF BIRTH:

I hereby request and authorize:

Agency:	Chippewa County Department of Human Services	**Attention:**
Address:	711 North Bridge Street	
City, State, & Zip Code:	Chippewa Falls, WI 54729	_____
Phone/FAX Number:	715-726-7788 **FAX:** 715-726-7736	

☐ **TO RELEASE TO** ☐ **TO OBTAIN FROM** ☐ **TO EXCHANGE WITH** ☐ **TO RELEASE TO SELF**

Name:	**Phone/FAX Number:**
Agency:	
Address:	_____
City, State, & Zip Code:	

the following information from my records:

☐ Verbal Information
☐ Psychological Tests/Evaluation(s)
☐ Behavioral Health Records:
  ☐ Assessments ☐ Clinical Notes
  ☐ Treatment Plan ☐ Discharge
☐ Social Work Reports
☐ Medical and/or Related Health Records
☐ Financial Records/Accounts
☐ Student Academic/Administrative Records
☐ Vocational Records/Evaluation(s)
☐ Other: ____

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release treatment records pertaining to:

☐ Mental Health ☐ Alcohol Abuse ☐ Drug Abuse
☐ Developmental Disabilities ☐ Other _____

Time period for which records are requested:

☐ From (date) ____ to ____ ☐ All ☐ Update

The purpose of such disclosure is:

☐ Verify/Determine Eligibility for Services
☐ Evaluation and/or Placement
☐ Provide Case Management
☐ Provide Treatment Services
☐ Continuity of Care*
☐ Other(Specify): ____

**Coordination of care received by a patient over time and across multiple health care providers.*

- ☐ I also specifically authorize the release of my medical information **created after the date of my signature.**
- I hereby release Chippewa County from all legal responsibility or liability that may arise from this act. I also understand that a copy of this release will be considered as valid as the original.
- Unless cancelled or otherwise noted below, **this authorization will remain in effect for one year**.
  ☐ Authorization expires as of _____ (date).

In compliance with Wisconsin law, which requires special permission to disclose otherwise privileged information, I specifically authorize the use and disclosure of my "highly confidential information" selected above, if any. I have had an opportunity to review and understand the content of this authorization form, including the notices that appear on the back of this form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Client:		Date:
Signature of Person Legally Authorized to Consent:	**Relationship**	**Date:**

CHIPPEWA COUNTY DEPARTMENT OF HUMAN SERVICES

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

REDISCLOSURE NOTICE TO PATIENT: I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards if such person(s) and/or organization(s) re-disclose my health information.

DISCLOSURE NOTICE TO RECIPIENT OF PATIENT HEALTH CARE RECORDS: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

DISCLOSURE NOTICE TO RECIPIENT OF MENTAL HEALTH, ALCOHOL, AND/OR DRUG TREATMENT RECORDS: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

- **Right to receive a copy of this authorization** – I understand that if I sign this authorization, I will be provided with a copy of this authorization.
- **Right to refuse to sign this authorization** – I understand that I am under no obligation to sign this form and that the person(s) and/or organizations(s) listed on the other side may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization except regarding:
    - research-related treatment
    - the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party
    - other exceptions (specify) _____
- **Right to withdraw this authorization** – I understand I may cancel this authorization at any time. If I want to cancel this authorization, I must do so in writing and give the written cancellation document to the agency I authorized to release information. I understand that my cancellation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed herein have made prior to receipt of my cancellation form.
- **Right to inspect or copy the health information to be used or disclosed** – I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. **Except for medication/somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances. (Section 51.30 Wisconsin Stats HFS 92.03-02-06 Wisconsin Adm. Code)**
- **Mental health treatment records** – I understand that I have the right to inspect and receive a copy of my mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.
- **Re-release of records – Chippewa County Department of Human Services will not re-release records without a court order or client release.**