

**WINNEBAGO COUNTY DEPARTMENT OF HUMAN SERVICES**  
**AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION**

WITH REGARD TO:

PRINT CONSUMER NAME (S) (FIRST, MI, LAST, SUFFIX)

DATE OF BIRTH (MM/DD/YYYY)

I HEREBY AUTHORIZE WINNEBAGO COUNTY DEPARTMENT OF HUMAN SERVICES:  MENTAL HEALTH  ALCOHOL AND OTHER DRUG ABUSE (AODA)  
 CHILD WELFARE DIVISION  ECONOMIC SUPPORT DIVISION  BENEFIT SPECIALISTS  LONG TERM SUPPORT DIVISION  
 MEDICAL RECORDS  OTHER – SPECIFY: \_\_\_\_\_

TO:  RELEASE TO  OBTAIN FROM  
INDIVIDUAL/AGENCY/DIVISION/TEAM \_\_\_\_\_

ADDRESS, CITY, STATE, ZIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

**THE FOLLOWING SPECIFIC INFORMATION:**

<input type="checkbox"/>	Admission Report	<input type="checkbox"/>	Individual Family Service Plan	<input type="checkbox"/>	Residential Records
<input type="checkbox"/>	Billing Information	<input type="checkbox"/>	Informal/Deferred Prosecution Agreement Contract	<input type="checkbox"/>	School Behavioral Records
<input type="checkbox"/>	Child Abuse/Neglect Reports	<input type="checkbox"/>	Intake/Initial Assessment	<input type="checkbox"/>	School Eval Report
<input type="checkbox"/>	Collateral Information	<input type="checkbox"/>	Law Enforcement	<input type="checkbox"/>	School Progress Records
<input type="checkbox"/>	Court Related Information	<input type="checkbox"/>	Legal Status Documents	<input type="checkbox"/>	School Pupil Records
<input type="checkbox"/>	Diagnosis	<input type="checkbox"/>	Mailing Address	<input type="checkbox"/>	Special Education
<input type="checkbox"/>	Discharge Summary	<input type="checkbox"/>	Medication Records/Lab Results	<input type="checkbox"/>	SSTOP client community service requirements &why
<input type="checkbox"/>	Disclosure of Client Status	<input type="checkbox"/>	Medicaid Waiver Program	<input type="checkbox"/>	Substance Abuse Assessment/Diagnosis
<input type="checkbox"/>	Drug Test Results	<input type="checkbox"/>	Medical Records	<input type="checkbox"/>	Substance Abuse Discharge Summary
<input type="checkbox"/>	Family Care Enrollment Form	<input type="checkbox"/>	OWI Findings	<input type="checkbox"/>	Substance Abuse Progress Notes
<input type="checkbox"/>	Financial Information	<input type="checkbox"/>	Patient Health Care	<input type="checkbox"/>	Substance Abuse Treatment Plan
<input type="checkbox"/>	Guardianship Records	<input type="checkbox"/>	Progress/Care Notes	<input type="checkbox"/>	Treatment Plan
<input type="checkbox"/>	Health Form	<input type="checkbox"/>	Psychiatric Evaluation/Notes	<input type="checkbox"/>	Verbal Progress Report/Observation
<input type="checkbox"/>	HIV/AIDS Status	<input type="checkbox"/>	Psychological Evaluation	<input type="checkbox"/>	Verbal-Written Information Exchange
<input type="checkbox"/>	Impressions/Recommendations	<input type="checkbox"/>	Psychological Treatment Records	<input type="checkbox"/>	Vocational Records
<input type="checkbox"/>	Individual Education Plan (IEP)	<input type="checkbox"/>	Pupil Physical Health	<input type="checkbox"/>	Other (specify): _____

**YOU MAY GO BACK TO THE PERSONS BIRTH, START OF SERVICES, OR A SPECIFIC DATE, BUT CANNOT GO FORWARD MORE THAN ONE YEAR FROM THE DATE THE RELEASE IS SIGNED.**

**COVERING THE PERIOD OF TIME:**

FROM:  
(MONTH/DATE/YEAR)

TO:  
(MONTH/DATE/YEAR)

FOR THE PURPOSE OF:  ASSESSMENT  BILLING  ELIGIBILITY DETERMINATION  SERVICE COORDINATION  TREATMENT  
 OTHER \_\_\_\_\_

IF APPLICABLE, RETURN INFORMATION TO:

NAME

DIVISION

TELEPHONE NUMBER

TO THE LOCATION INDICATED BELOW:

<input type="checkbox"/> 220 Washington Ave., P.O. Box 2187, Oshkosh, WI 54903-2187	<input type="checkbox"/> 211 N. Commercial St., Neenah, WI 54956
<input type="checkbox"/> 684 Butler Ave, Oshkosh, WI 54901	<input type="checkbox"/> Other: _____

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**AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION**

PRINT CONSUMER NAME (S) (FIRST, MI, LAST, SUFFIX)

DATE OF BIRTH (MM/DD/YYYY)

**Note to Disclosing Agency:** Be advised that any information you disclose to Winnebago County Department of Human Services may become a part of the consumer's permanent record and, as such, will be accessible to that person per the requirements of DHS 92.

**Note to Receiving Agency:** Be advised that Chapter 51 of Wisconsin State Statute prohibits you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains. Also, federal rules pertaining to AODA treatment prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Note to Consumer and Disclosing Agency:** Be advised that any disclosure of information pursuant to this authorization carries with it the potential for an unauthorized re-disclosure after which the information may no longer be protected by the federal privacy standards.

**I understand** that I have the right to confidentiality of my treatment records and that disclosure without my consent or other statutory authorization is prohibited by law. **I understand** that I have the right to inspect and receive a copy of any material to be disclosed (as required under DHS 92) unless not allowed under more restrictive requirements of Ch. 48 (Children's Code) or 938 (Juvenile Justice Code) of the Wisconsin Statutes. **I understand** that when the request for disclosure of information comes from me I may be charged a uniform fee for reproduction of the record. **I understand** that sub-units of the department (except for the alcohol and other drug abuse sub-unit) exchange confidential information about a consumer with any other sub-units, and with any service providers who have a services contract with the department, if such information is necessary to enable an employee or service provider to do his or her job, or to enable the department to coordinate services for the consumer.

**I understand** that I have the right to refuse to sign this authorization and to revoke this authorization at any time after signature except that revocation cannot be retroactive. **I understand** that generally this agency may not condition treatment on whether I sign a consent/authorization form, but that in certain circumstances I may be denied treatment if I do not sign a consent/authorization form.

**I agree** to indemnify and hold harmless the above-named agencies/individuals from any liability that may arise from the records release/receipt authorized herein. Unless revoked in writing this authorization will remain in effect for a period of one year from the date of signature, or until the purpose of the authorization has been realized, whichever comes first.

<b>THERE MAY BE A CHARGE FOR THIS REQUEST. A PHOTOCOPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL.</b>	
<b>SIGNATURE:</b>	<b>DATE:</b>
<b>ARE YOU:</b> <input type="checkbox"/> CONSUMER <input type="checkbox"/> PARENT OF MINOR <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> ACTIVATED DPOA-HC <input type="checkbox"/> LEGAL CUSTODIAN	
<b>PLEASE PRINT NAME:</b>	<b>PHONE NUMBER:</b>
<b>SIGNATURE:</b>	<b>DATE:</b>
<b>ARE YOU:</b> <input type="checkbox"/> CONSUMER <input type="checkbox"/> PARENT OF MINOR <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> ACTIVATED DPOA-HC <input type="checkbox"/> LEGAL CUSTODIAN	
<b>PLEASE PRINT NAME:</b>	<b>PHONE NUMBER:</b>
<b>SIGNATURE OF WITNESS: (if applicable)</b>	<b>DATE:</b>
<b>PLEASE PRINT WITNESS NAME:</b>	
<b>PER HIPAA 164.508(c)(4), CONSUMER MUST BE GIVEN A SIGNED COPY OF THIS FORM</b>	