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:

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

☐	220 Washington Ave., P.O. Box 2187, Oshkosh, WI 54903-2187	☐	211 N. Commercial St., Neenah, WI 54956
☐	684 Butler Ave, Oshkosh, WI 54901	☐	Other:

WINNEBAGO COUNTY DEPARTMENT OF HUMAN SERVICES
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.

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