FOLLOW THE 8 STEPS OUTLINED BELOW TO ENSURE YOUR RELEASE IS VALID

If you have any questions, please contact Records Staff

Email: DHSRecordsRequest@co.winnebago.wi.us • Phone: 920-236-4732 • Fax: 920-236-1277

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)

1. WHOSE RECORDS ARE BEING RELEASED?
Consumer's name(s), include children's name for CPS Records.
Date of Birth

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:

2. WHAT DEPARTMENT HOLDS THE RECORDS?

TO: ☒ RELEASE TO ☐ OBTAIN FROM
INDIVIDUAL/AGENCY/DIVISION/TEAM
ADDRESS, CITY, STATE, ZIP:
PHONE NUMBER:

3. WHERE ARE THE RECORDS GOING?
Are you picking them up?
Are they going to a doctor's office? Attorney's Office?
Include the fax number and phone number or email address.

THE FOLLOWING SPECIFIC INFORMATION:

4. WHAT SPECIFCALLY ARE YOU LOOKING TO RELEASE?
*Check all boxes that may apply. Specify if checking **OTHER:***

☐	Admission Report	☐	Individual Family Service Plan	☐	Residential Records
☐	Billing Information	☐	Informal/Deferred Prosecution	☐	School Behavioral Records
☐	Child Abuse/Neglect Reports				
☐	Collateral Information				cords
☐	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 DA OM THE DATE THE RELEASE IS SIGNED.

COVERING THE PERIOD OF TIME: FROM: (MONTH/DATE/YEAR)

5. PERIOD OF TIME YOU WANT RECORDS RELEASED
Example: 01-01-1999 to 05-05-2005
Start of Services or Treatment to current date
Birthdate to current date

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

6. FOR WHAT PURPOSE?
Check boxes that may apply
In OTHER: enter if self-request or legal purpose

IF APPLICABLE, RETURN INFORMATION TO: ELEPHONE 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:

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7. WHOSE RECORDS ARE BEING RELEASED?
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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 ds release/receipt authorized herein. Unless re ne date of signature, or until the purpose of the

8. WHO'S AUTHORIZING THE RELEASE?
Consumer, Parent, Guardian?
Include Signature, Printed name, Date and Phone Number
Anyone over the age 18 must authorize/sign release for release of their records.
If the release is not signed in front of office staff, release must be notarized*

THERE MAY BE A CHARGE FOR THIS RI	
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	