



**CHIPPEWA COUNTY DEPARTMENT OF HUMAN SERVICES**  
**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**



<b>CLIENT NAME:</b>	<b>DATE OF BIRTH:</b>
---------------------	-----------------------

**I hereby request and authorize:**

<b>Agency:</b> Chippewa County Aging & Disability Resource Center	<b>Attention:</b> Kay Hebert Breanna Schemenauer
<b>Address:</b> 711 North Bridge Street Room 118	
<b>City, State, &amp; Zip Code:</b> Chippewa Falls, WI 54729	
<b>Phone/FAX Number:</b> 715-726-7777 <b>FAX:</b> 715-738-2589	

- TO RELEASE TO     
  TO OBTAIN FROM     
  TO EXCHANGE WITH     
  TO RELEASE TO SELF

<b>Name:</b>	<b>Phone/FAX Number/Email:</b>
<b>Agency:</b>	
<b>Address:</b>	
<b>City, State, &amp; Zip Code:</b>	

**the following information from my records:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Verbal Information  | <input type="checkbox"/> Social Work Reports                   | <input type="checkbox"/> Student Academic/Administrative Records |
| <input type="checkbox"/> Psychological Tests/Evaluation(s)   | <input type="checkbox"/> Medical and/or Related Health Records | <input type="checkbox"/> Vocational Records/Evaluation(s)        |
| <input type="checkbox"/> Behavioral Health Records:  | <input type="checkbox"/> Financial Records/Accounts            | <input type="checkbox"/> Other: _____                            |
| <input type="checkbox"/> Assessments <input type="checkbox"/> Clinical Notes<br><input type="checkbox"/> Treatment Plan <input type="checkbox"/> Discharge |  |  |

<b>In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release treatment records pertaining to:</b>
<input type="checkbox"/> Mental Health <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Developmental Disabilities <input type="checkbox"/> Other _____

**Time period for which records are requested:**

- From (date) \_\_\_\_\_ to \_\_\_\_\_     
  All     
  Update

**The purpose of such disclosure is:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Verify/Determine Eligibility for Services | <input type="checkbox"/> Provide Case Management    | <input type="checkbox"/> Continuity of Care*   |
| <input type="checkbox"/> Evaluation and/or Placement               | <input type="checkbox"/> Provide Treatment Services | <input type="checkbox"/> 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 (typing in my name) this authorization, I am confirming that it accurately reflects my wishes.**

<b>Signature of Client:</b>	<b>Date:</b>
<b>Signature of Person Legally Authorized to Consent:</b>	<b>Relationship:</b>
	<b>Date:</b>



**REDISCLASURE 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.