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DEPARTMENT OF HUMAN SERVICES *LIZA DRAKE, Director*

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, _____ authorize the Ozaukee County Department of Human Services,
(**Print name of client**) (Date of Birth)

☒ *to disclose to* (-or-) ☒ *receive from* **[check one or both]** the records and information specified below:

_____
(Name of Person or Organization)

_____
(Address)

- **TYPE OF INFORMATION TO BE RELEASED:** **X** Verbal **X** Written
- **SPECIFIC INFORMATION TO BE RELEASED:**

NO	YES		NO	YES	
☐	☐	TREATMENT SUMMARY PLAN	☐	☐	SUMMARY OF ALL SERVICES
☐	☒	PROGRESS NOTES			FROM ____ TO _____
☐	☐	ASSESSMENT RESULTS	☐	☐	PSYCHOLOGICAL EVALUATION
☐	☐	RECOMMENDATIONS	☐	☐	PSYCHIATRIC EVALUATION
☐	☐	DRUG TESTING RESULTS	☐	☐	SOCIAL HISTORY/ASSESSMENT
☐	☐	DIAGNOSIS/PROGNOSIS	☐	☐	MEDICATIONS
☐	☒	ONGOING VERBAL EXCHANGE OF INFORMATION BETWEEN TWO PARTIES ABOVE			
☐	☐	OTHER (SPECIFY) _____			

- **THE PURPOSE FOR THE DISCLOSURE OF THE INFORMATION IS:**

	NO	YES
A. To assist in evaluation, treatment planning and service coordination	☐	☒
B. To facilitate family involvement in treatment/evaluation	☒	☐
C. To coordinate treatment services between providers	☐	☒
D. To complete Juvenile Court Intake/Disposition Assessment	☒	☐
E. To determine eligibility for services	☒	☐
F. Other reasons: (Specify reason if YES is checked)	☐	☒

Case management – CLTS Waiver Program

I understand that my records are protected under the Federal and specific State confidentiality laws and regulations
~~(Initial one or both):~~ ~~_____ Chemical Dependency, Federal Regs 42 CFR, Part 2 or _____ Mental Health, Chapter 51.30~~
~~and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that by my written notification I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that, in any event, this consent expires automatically as described below. I understand that if the person and/or agency listed above are not governed by applicable federal and state laws and administrative codes, the confidential information disclosed as a result of this authorization may no longer be protected from further redisclosure without obtaining my authorization.~~ N/A

I understand that I have a right to inspect and receive a copy of the material to be disclosed as required under Wisconsin law, ss.51.30(4) and HFS 92.05 and 92.06 of the Wisconsin Administrative Code, as well as the Privacy Rule of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. A copy of this authorization will be considered as valid as the original.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

THIS RELEASE EXPIRES UPON THE FULFILLMENT OF THE PURPOSE FOR WHICH THIS RELEASE WAS ENACTED AND IN ANY EVENT, SPECIFICALLY **EXPIRES ONE YEAR FROM THE DATE OF SIGNATURE.**

Signature of Client/Legal Representative: _____ **Date:** _____
Signature is that of: ☐ Client/Patient ☐ Parent of Minor ☐ Legal Guardian ☐ Other Legal Representative

Signature of witness (or legally authorized minor): _____

Agency Worker obtaining Consent: _____

DISTRIBUTION: White Copy – Source of Information Yellow Copy – Client/Patient OCDHS REVISED: May 2016