WASHINGTON COUNTY HUMAN SERVICES DEPARTMENT

333 E. Washington Street, PO Box 2003, West Bend, WI 53095-2003
262/335-4600
☒ Suite 2100 Fax 262/335-6827 ☐ Acute Care Fax 262/365-6559
☒ Suite 3100 Fax 262/335-4709

Send to BDS

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH, MENTAL HEALTH, ALCOHOL/DRUG ABUSE OR HUMAN SERVICES ASSISTANCE INFORMATION

Name of Client/Subject of Record _____ Date of Birth _____

Address _____ Telephone _____

I authorize Washington County Human Services Department to: (Check all that apply)

☒ Obtain From: Agency/Individual _____

☒ Release To: Address _____

☒ Verbal ☒ Written Telephone _____

Name or initials of Staff person/program making this request _____

With this authorization, I understand that the Washington County Human Services Department can share written and/or verbal information regarding services I have received with the above named agency/individual. I understand that the sub-units of Washington County Human Services Department, which are subject to state and federal confidentiality laws including HIPAA may exchange information internally as needed pertaining to specific work activities.

Dates of records/services **MUST** be specified: _____ (Month/Year) to _____ (Month/Year)

HUMAN SERVICES DIVISION/PROGRAM

Communication(s)/Record(s)
Check all that apply

- ☐ Alcohol/Drug Abuse Records
- ☐ Child/Family Records
- ☒ Developmental Disabilities Records
- ☐ Economic Support Records (SS# _____)
- ☒ Mental Health Center Records
  - ☐ Acute Care Crisis Intervention Records
- ☐ Billing/Insurance Claims Records
- ☐ FAX Records to Fax #_____

Document(s)/Record(s) to be released
Check all that apply

- ☒ Letter/Treatment Summary
- ☒ Progress Notes
- ☒ Discharge Summary
- ☐ Psychosocial History
- ☐ Psychiatric Evaluation
- ☐ Psychological Evaluation
- ☒ Medications
- ☒ Treatment Plans
- ☐ Aftercare Plans
- ☒ Clinical Assessment
- ☐ Employment Information
- ☐ School Transcripts
- ☐ Insurance/Funding Info
- ☒ Other (specifically describe)
  verbal information about CLTS services

PURPOSE OR NEED FOR RELEASE OF INFORMATION (BE SPECIFIC)

- ☐ Request of individual
- ☐ Personal Knowledge
- ☐ Transfer of Services
- ☐ Attorney/Legal
- ☐ Collateral
- ☐ Insurance/Billing
- ☐ Case Management
- ☐ Coordination of Services
- ☐ Chapter 51/55 Monitoring
- ☒ Continuity of Care
- ☐ Relocation/Moving
- ☒ Other: info specific to CLTS

This authorization will expire one year from the date of signature unless otherwise specified: _____

I authorize the release of copies of any service records accumulated after my signature through the expiration date of this consent form. Records are released at a cost of .25 cents per page.

_____ _____
Original Signature of Subject of Information/Records Required Date

If signed by person other than subject of information/records, state relationship and authority to do so.

_____ _____
Signature of Parent and/or Guardian Required Date
Client is: ☒ Minor ☐ Incompetent ☐ Deceased ☐ Has Legal Custodian Documentation Provided ☐

_____ _____
Signature Revoking Authorization Date