WAUKESHA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH OR CONFIDENTIAL INFORMATION

Send to BDS

1) CLIENT INFORMATION: (please print)

Name/Previous Name(s): _____ Date of Birth: _____ Phone Number: _____

Address (include City, State, Zip Code): _____

2) AUTHORIZES WAUKESHA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES (WCDHHS) AT:

☒ Health & Human Services - 514 Riverview Ave., Waukesha, WI 53188
☐ Outpatient AODA/MH Clinic at HHS - 514 Riverview Ave., Waukesha, WI 53188
☐ Mental Health Center - 1501 Airport Rd., Waukesha, WI 53188
☐ Public Health – 514 Riverview Ave., Waukesha, WI 53188

Attention: CLTS Waiver Service Coordinator

3) TO: ☒ DISCLOSE TO: ☒ OBTAIN FROM: ☒ VERBALLY EXCHANGE WITH:

Name of Individual/Agency/Organization/Other: (Name of fiscal agent employee)

Address (include City, State, Zip Code): _____

Phone Number: _____ Fax Number: _____

Method of Release: ☒ Paper Release ☒ Electronic/Digital Release (specify) Any and all information
Release By: ☒ US Mail ☐ Fax ☐ Pick-Up: Location _____
☐ To be picked up by: _____

4) INFORMATION TO BE DISCLOSED:

Note: Information to be released may be in Written, Verbal, Voicemail, Fax or Electronic Form

☐ Intake/Initial Assessment	☐ Discharge Summary	☒ Appointments/Attendance	☒ Child & Family Records
☒ Medications	☐ Medical Evaluations/H & P	☐ Access Reports	☐ Juvenile Records
☒ Staffing/Progress Notes	☐ Psychological Evaluation	☐ Educational Records	☐ Public Health Records
☒ Treatment Plan/Reviews	☐ Psychiatric Evaluation	☐ Financial Information	☒ Social History
☐ Adult Human Services Records	☐ Laboratory Reports	☒ Other (Specify): Information specific to the CLTS Waiver Program	

5) In compliance with WI Statutes, which require special permission to release otherwise privileged information, please release records pertaining to (check all that apply):

☐ Alcohol or Drug Abuse/Treatment (AODA) ☒ Mental/Behavioral Health Conditions ☐ HIV/AIDS
☒ Developmental Disabilities ☐ Sexually Transmitted Diseases

6) DATE(S) OF INFORMATION TO BE DISCLOSED: FROM: _____ TO: _____

7) PURPOSE OF DISCLOSURE:

☒ Continuing Care ☐ Legal Matters ☐ Insurance/Eligibility/Benefits
☐ Educational Planning ☐ Personal ☒ Other: (Please specify): Information specific to the CLTS Waiver Program

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Receive a Copy of the Confidential Information to be Used or Disclosed: I understand that I have the right to inspect or receive a copy of the health or confidential information I have authorized to be used or disclosed by this authorization form except for the information not authorized by law. I may arrange to inspect my health or confidential information or obtain copies of my confidential information by contacting WCDHHS. **I understand that I may be charged a reasonable fee for record copies. Right to Receive a Copy of this Authorization:** 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. **Right to Refuse to Sign this Authorization:** I understand that I am under no obligation to sign this form and that WCDHHS may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. ****WI Statutes 51.30 and 252.15** requires client authorization to disclose health information for payment purposes. A consequence of refusal to sign an authorization for disclosure pursuant to WI Statutes 51.30 or 252.15 records may be non-payment. **Right to Revoke this Authorization:** I understand that I can cancel this authorization at any time by providing a written notification to the WCDHHS Centralized Records Supervisor or to the disclosing individual/organization in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures of my health or confidential information that the person(s) and/or organization(s) above have already made in reliance upon this Authorization before receipt of the written notice of revocation; or needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage.****HIV/AIDS Test Results:** I understand my HIV test results may be released without an authorization to persons/organizations that have access under state laws and a list of those persons/organizations is available upon request. **Re-Disclosure Notice:** I understand that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. The third party may not be required to abide by this Authorization or applicable Federal and State laws governing the use and disclosure of my health or confidential information. This information has been disclosed from records protected by Federal (42 CFR Part 2) and Wisconsin (51.30) confidentiality rules. The Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent 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 client. A copy or facsimile (FAX) of this authorization will be considered valid as the original.

9) EXPIRATION: This authorization is good until the following event/date: _____ or for up to one year from the date signed.

10) By signing this authorization, I am confirming that I have had an opportunity to review and understand the content of this authorization form and that it accurately reflects my wishes. I am also confirming that I have read and understand the rights with respect to this authorization.

11) SIGNATURE OF CLIENT: _____ **DATE:** _____

12) SIGNATURE OF PARENT/GUARDIAN/OTHER: _____ **DATE:** _____

If signed by a person other than the client, complete the following:

1. Client is: ☒ Minor ☐ Incompetent ☐ Unable to sign due to disability ☐ Deceased
2. Legal Authority: ☐ Parent of Minor ☐ Legal Guardian* ☐ Power of Attorney (POA)* ☐ Other*: _____

If you check any of the above boxes, you must have proof of legal authority attached to this authorization before any records will be released. (i.e. Guardianship Papers, Power of Attorney documents)

For Office Use Only: Staff Person Assisting Client to Complete Authorization: _____

HHS-FM-6246-AA, 07/12, 09/13 **ROUTING: White: Agency** **Pink: Client**