☐ **APS** ☐ **B3** ☐ **CLTS** ☐ **CPS** ☐ **CSP** ☐ **ES**
☐ **ISP (CCS/FCF)** ☐ **JDS** ☐ **MH** ☐ **RRSS –MAT** ☐ **SU** ☐ **YJ**

Sauk County Department of Human Services
P. O. Box 29, Baraboo, WI 53913

Phone (608) 355-4200
Records Fax (608) 355-4294

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH/SERVICE INFORMATION

Name of Individual/Previous Names **Date of Birth**

AUTHORIZES:
Sauk County Dept. of Human Services
P. O. Box 29
Baraboo, WI 53913

TO: ☐ EXCHANGE ☐ RELEASE ☐ RECEIVE PROTECTED HEALTH/SERVICE INFORMATION WITH:

Individual/agency/organization receiving information

Street Address

City, State, Zip Code

Phone/Fax

INFORMATION TO BE RELEASED:
Format: ☐ Verbal ☐ Written ☐ Fax

☐ Assessment
☐ Case Management Services
☐ Court Information
☐ Early Intervention Records
☐ Educational Evaluation Reports & IEP
☐ Financial Information
☐ HIV/AIDS
☐ Medication/Medical
☐ Progress Notes
☐ Psychiatric Evaluation
☐ Psychological Evaluation
☐ Redisclose **3rd Party** Records
☐ Social History
☐ Substance Use Records
☐ Summaries _____
☐ Therapy Evaluation & Reports
☐ Treatment Plan
☐ Vocational Records
☐ Other (Specify): _____

Records to be disclosed are between the dates of _____ and_____.

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)
☐ Aftercare Follow-up
☐ Changing Providers
☐ Continuity of Care
☐ Educational Planning
☐ Further Medical Care
☐ Insurance/Eligibility/Benefits
☐ Legal Investigation or Action
☐ Personal
☐ Program Eligibility
☐ Other (Specify): _____

EXPIRATION DATE: This authorization is valid for <u>one year</u> from the date of Authorized Signature. For <u>less than</u> one year, please indicate date: Authorization expires as of _____.

****PLEASE SEE REVERSE FOR FURTHER INFORMATION****

In accordance with the conditions listed above and on the reverse side of this form, I authorize the use and/or disclosure of my Health/Services information.

Client Signature

Date of Client or Authorized Signature

Other Authorized Signature*****

Witness Signature

Legally authorized because client is: ☐ Minor ☐ Guardianship ☐ Unable to sign due to disability ☐ Deceased

*****Legal Authority: ☐ Parent of Minor ☐ Legal Guardian/Representative ☐ Spouse

All persons signing for release of records instead of the client must state their relationship to the client and have available proof of legal authority prior to the release of the records.

A photocopy, fax, or email copy of this Authorization for Disclosure of Confidential Information is as valid as an original.

Records Department Action: ☐ **Disclose Information** ☐ **Obtain Information** ☐ **Send Authorization** ☐ **No Immediate Action Needed**

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL

ADDITIONAL INFORMATION REGARDING RELEASE OF HEALTH/SERVICE INFORMATION

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records, which are protected by Federal Register '42 CFR Part 2"; '45 CFR Parts 160-164"; Wis. Stats. § 51.30; Wis. Stats. § 146.38; Wis. Stats. § 146.81 (2); and Chapter DHS 92 of the Wisconsin Administrative Code. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without specific written consent of the client or their legal representative.

Right to Refuse to Sign This Authorization - You are under no obligation to sign this form and refusal will not affect the commencement, continuation, or quality of services you receive at Sauk County Department of Human Services; except however, if your services at Sauk County Department of Human Services are for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Sauk County Department of Human Services may refuse to provide services to you if you do not sign this Authorization.

Revocation. You have the right to revoke this authorization at any time by providing a written statement of withdrawal to the Sauk County Department of Human Services. However, your written revocation will not be effective until received by Sauk County Department of Human Services and will not be effective regarding the uses and/or disclosures of health/service information that Sauk County Department of Human Services has made prior to receipt of your withdrawal statement. You understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Right to Receive a Copy of this Authorization - If you agree to sign this Authorization, which you are not required to do, you must be provided with a signed copy of the form.

Right to Inspect or Copy the Health/Service Information to be Used or Disclosed - You have a right to inspect or copy the health/service information authorized to be used or disclosed by this Authorization form except for records of medication and somatic treatment. This right may be denied by the treatment facility director, or designee, during the client's treatment under certain circumstances. You may arrange to inspect your health/service information or obtain copies of health/service information by contacting Sauk County Department of Human Services.

A uniform and reasonable fee may be charged for a copy of the records, which fee may be reduced or waived in accordance with agency policy for those clients who show an inability to pay. Section 51.30(4)(d), Wisconsin Statutes, and Sections DHS 92.03(3)(d), 92.05, and 92.06, Wisconsin Administrative Code.

Wisconsin Statutes recognizes the need for informed consent in certain circumstances. The Authorization is limited to records dated up to and including the date specified by the client on this form. A new Authorization will be necessary for releases of information on care provided after the date specified by the client.

Re-release. Once Sauk County Department of Human Services discloses your health/service information to the recipient, Sauk County Department of Human Services cannot guarantee that the recipient will not re-disclose health/service information to a third party. The third party may not be required to abide by this Authorization or applicable Federal and State law governing the use and disclosure of your health/service information.