1707 Main Street La Crosse, WI 54601 (Agency Main Branch) | (608) 785-0001

**AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION**

# Section 1: INDIVIDUAL WHO IS SUBJECT OF RECORD:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name-Last, First, M.I. Date of Birth Telephone #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address City State Zip Code

**Section 2*:***

**AUTHORIZES THE RELEASE OF PROTECTED HEALTH INFORMATION BETWEEN:**

 Family & Children’s CenterAgency Name & Address

**[ ]** All programs & locations as needed, OR **[ ]**  All FCC programs & locations as needed, OR

 **[ ]** Only the programs/locations designated below **[ ]** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 3: INFORMATION TO BE OBTAINED, EXCHANGED &/or RELEASED:**

In compliance with State and Federal Laws which require special permission to release otherwise privileged information, please release records pertaining to:

**[ ]** Mental Health**[ ]** Alcohol and/or Drug Abuse**[ ]** Developmental Disability**[ ]** HIV

**[ ]** Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4: SPECIFIC RECORDS AUTHORIZED TO OBTAIN, EXCHANGE &/or RELEASE:** **[ ]** Health Check**[ ]** Discharge Summary**[ ]** County Records **[ ]** Medications **[ ]** Report Cards

**[ ]** Diagnosis/Client History**[ ]** Progress Notes**[ ]** Treatment Plan(s)**[ ]** Billing Records Academic/IEP

**[ ]** Medical/Dental Records**[ ]** Aftercare Plan**[ ]** Consultations**[ ]** Assessments/Evaluations

**[ ]** Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### For the following date(s): FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 5: PURPOSE FOR NEED OF DISCLOSURE:**

**[ ]** Coordination of Care**[ ]** Treatment Planning**[ ]** Diagnostic Assessment**[ ]** Management of Insurance**[ ]** Legal

**[ ]** Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 6: EXPIRATION DATE: (A photocopy or faxed version of this authorization is as valid as the original)**

I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that I have the right to refuse to sign this authorization. I understand that this authorization allows for records after the date of the signature to be released, up to and including the expiration date of this release indicated below (maximum 1 year). ***One of the following MUST be checked:***

**[ ]** 90 Days from date of signature**[ ]** Authorization expires (specify date or event): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ]** Ongoing written, verbal & electronic communication during treatment; expires 12 months from signature date.

**Section 7: SIGNATURES:**

By signing this authorization, I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on me signing this authorization. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I have the right to inspect and receive a copy of this Authorization and the material to be disclosed. Copies of records may be obtained with reasonable notice and payment of copying costs.

## Client/Legal Authority Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Client/Legal Authority Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\**If signed by a person other than the identified client, state relationship and authority to do so below.**

You may be asked to provide documentation showing that you are the client’s legally authorized representative.

Client is:Minor IncompetentIncapacitatedDeceased

Legal Authority:Biological ParentAdoptive ParentLegal GuardianOther

**Minor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Minor Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#### ADDITIONAL INFORMATION REGARDING

**THE DISCLOSURE OF HEALTH INFORMATION**

**Additional Explanation of Rights with Respect to This Authorization:**

* You have the right to inspect and receive a copy of this Authorization for Use & Disclosure of Health Information

 and the material to be disclosed as required under Wisconsin Statutes ss. DHS 92.05 and 92.06, and Minnesota Statues Section 144.292 (4). Except for records of medication and somatic treatment, the treatment facility director, or designee, may deny this right during the client’s treatment under certain circumstances.

* A uniform and reasonable fee may be charged for a copy of the records, which may be reduced or waived in accordance with agency policy for those clients who show inability to pay. Section 51.30 (4)(d), Wisconsin Statutes and Section DHS 92.03 (3)(d), 92.05 and 92.06, Wisconsin Administrative Code and Minnesota Statutes Section 144.293 (3) and Section 144.292 (5).
* Wisconsin and Minnesota Statutes recognize the need for informed consent. The release of information is limited to records dated up to and including the date specified on this form. This release of information allows for records after the date of the authorizing signature to be released up to and including the expiration date of the authorization. A new authorization will be necessary for release of information for care provided after the date specified.

Generally**, all clients 18 years and older** must sign for the disclosure of information, unless one of the following conditions applies:

* The client is incompetent.
* The client is incapacitated and unable to sign the form.
* The client is deceased (the surviving spouse or legal representative must sign authorization releasing records of deceased client).

##### **Mental Health Records**

* 1. Wisconsin Law: All clients **14 years** of age and older may sign for disclosure of client information involving treatment for mental illness or developmental disabilities. Parents generally may also consent, unless denied physical placement of the client. When a parent consents for a client **14 years** of age or older, it is recommended that the client sign also.
	2. Minnesota Law: All clients **16** **years** of age and older may sign for disclosure of client information involving treatment for mental illness or developmental disabilities. Parents generally may also consent, unless denied physical placement of the client. When a parent consents for a client **16 years** of age or older, it is recommended that the client sign also.

##### **Alcohol & Drug Abuse Treatment Records**

##### Wisconsin Law: Clients **12 years** of age or older must sign for the disclosure of alcohol and drug abuse records unless the treating physician determines and documents that the minor is not capable.

1. Minnesota Law: Parents or legal guardians have the right to access alcohol or drug abuse treatment records **with the consent of the minor client**, unless the treating physician determines that his or her failure to inform the parent or guardian would seriously jeopardize the health of the minor client.

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

**NOTICE TO RECIPIENT OF INFORMATION:**  This information has been disclosed to you from confidential records, which are protected by Federal Register “42 CFR Part II” and “45 CFR 164,” WI DHS 92, WI Ch. 51.30, WI Ch. 146.81-146.84, & MN Statute 144.291-144.334. Federal rules prohibit you 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 II. 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 to prosecute any alcohol or drug abuse by patient.

**For Internal Use Only**

Document information disclosed, to whom, by whom, date and time of disclosure, and brief purpose of disclosure: