Outagamie County Release of Information

Client Information

Client Name: _____

DOB: _____ **Effective Date:** _____ **Program:** Records

Release of Information

General

I authorize Outagamie County and the selected named agencies/individuals to communicate, and exchange written and/or verbal information, if applicable. I release the named agencies/individuals from all legal responsibilities that may arise from this act. A uniform charge for reproduction will be assessed. I understand that sub-units of the department, which are subject to HIPAA, may exchange confidential information about individual served and with any providers who have a services contract with the department if such information is necessary to enable an employee or service provider to do his or her job, or to enable the department to coordinate services for the individual served. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization. SUD records authorized for disclosure by this release cannot be used or disclosed in civil, criminal, administrative, or legislative proceedings against me. This release does not permit the release of SUD counseling notes and requires an additional consent form.

Release To/Release From

Name or Other Specific Identification of Person(s) authorized to receive/ make the requested use or disclosure:

Organization/Provider: _____ Contact: _____

Type: ☐ Release To ☐ Obtain From

Contact Type: _____

Organization: _____

Name: _____

Address: _____ **E-mail:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax Number:** _____

Purpose of Disclosure (circle all that apply)

☐ Treatment
☐ To advocate on my behalf
☐ Other: _____
☐ Legal
☐ Care Coordination/Continuity of Care

Preferred Method of Delivery (circle all that apply)

☐ Paper (mail) ☐ Paper (Pick-Up) ☐ Encrypted Email ☐ Verbal ☐ Fax

Expiration

Start Date (date of signature): _____ **End Date (1 year from signature):** _____

Circle Applicable Division (ROI Type)

☐ Aging and Long Term Care (ALTS) ☐ Children, Youth, and Families (CYF) ☐ Economic Support/Child Support (ES/CS)

☐ Mental Health/AODA (MH) ☐ Public Health (PH) ☐ Youth and Family Services (YFS) ☐ General - Verbal

Information to be Used or Disclosed (circle all that apply)

The information that can be disclosed under this authorization includes the following, if available

☐ Diagnosis
☐ Psychological Evaluation(s) Reports
☐ Progress Review/Summary
☐ Education records/IEPs/504/IBP
☐ Progress Notes/Case Notes
☐ History and Physical
☐ Law Enforcement Records
☐ Pickup Medications
☐ Test Results
☐ Child Abuse/Neglect Reports
☐ Medical History, Lab Results, Immunizations Records
☐ Intake/Initial Assessment
☐ Medications Prescribed
☐ Financial Information
☐ Intake/Admission Information
☐ Discharge Summary/Plan
☐ AAPS Eligibility Documents
☐ Treatment Plan(s)
☐ Discuss Case Specifics
☐ Laboratory Results
☐ Make/Check on appointments
☐ Court Records
☐ Other_____

Records Start Date: _____ **Records End Date:** _____

In compliance with Federal and Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records including records received from other sources, pertaining to:

☐ Mental Health / Behavioral
☐ Developmental Disabilities
☐ Sexually Transmitted Infections
☐ HIV/AIDS
☐ Substance Use Disorder Discharge Summary
☐ Substance Use Disorder Treatment Plans
☐ Intoxicated Driver Assessment/Plan
☐ Substance Use Disorder Assessment
☐ Substance Use Disorder Progress Notes
☐ Substance Use Disorder - Test Results
☐ Other (Specify):_____

Restrictions

_____

_____

Terms

Your Rights with Respect to This Authorization Right to Inspect or Copy the Health Information to Be Used or Disclosed. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Officer at the Department of Health and Human Services, 320 S. Walnut Street, Appleton, Wisconsin, 54911. Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, A signed copy of the form may be available upon request. Right to Refuse to Sign This Authorization. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to Withdraw This Authorization. I understand written notification is necessary to cancel this authorization. Disclosure of Direct or Indirect Payment Received by Any Person or Organization Authorized to Use or Disclose my Health Information: I understand that Outagamie County Department of Health and Human Services will not be receiving any direct or indirect payment in connection with the use or disclosure of my health information. Note to the Patient and Receiving Agency: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The 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 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 patient.

By checking these boxes, I agree that I have read, understand and agree to these terms.

☐ NOTICE TO CLIENT: By submitting this form you are not required to receive any services from the agency.

☐ ACCESS TO MY RECORD: This request can take 30 days to complete and charges may apply.

Agency Information

Program: _____ **Attention:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Other

Copy Given to Client: ☐ Yes ☐ Declined a copy **Agency Staff:** _____

ID Verified By: ☐ Driver's License ☐ Other Picture ID ☐ Known to Agency

Additional Information

Please note - The records released may contain alcohol and drug abuse information and/or information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

Alcohol/Drug Abuse:

☐ **I authorize** the release of information relating to referral and/or treatment for alcohol and drug abuse.
☐ **I PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

☐ **I authorize** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.
☐ **I PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

Legal Authority (circle applicable below):

☐ Custodial Parent ☐ Legal Guardian ☐ Authorized Legal Representative

☐ Power of Attorney for Healthcare ☐ Executor of Estate of Deceased ☐ Self

Employee Signature: _____ **Signature Date:** _____

Client Signature: _____ **Signature Date:** _____