COLUMBIA COUNTY

Health and Human Services
111 East Mullett St.

608-742-9227
FAX: 608-742-9700
TDD: 608-742-9229
E-MAIL: DHHS@columbiacountywi.gov
WEBSITE: www.co.columbia.wi.us

Mailing Address: P.O. Box 136
Portage, WI 53901-0136

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Client Name: _____ **Birth Date:** _____

Address: _____ **Phone:** _____

_____

____ I want a copy of my record. Send it to me at the address listed above.

____ Share my record with: _____

_____

____ Get my record from: _____

_____

My record may be shared with other Divisions within Columbia County Health & Human Services Department such as:

ADRC ____ BHLTS ____ DES ____ DCF ____ DOH ____ ALL _____

The Following Records:

□ Letter/Treatment Summary □ Psychiatric/Psychological Eval □ Alcohol/Drug Abuse □ Employment
□ Therapy Progress Notes □ Intellectual Disabilities □ Long Term Support □ Lab Results
□ Inpatient/Outpatient Counseling □ Medications/H&P Records □ Court Records □ WIC
□ Psychosocial History □ Social History □ Education Eval/Records □ Personal References
□ Police Reports □ Communicable Disease □ All H&HS Records □ Blood Lead follow up
□ Prenatal Care Coordination □ Health Check Records □ Immunization Records □ Nurse Family Partnership
□ HHS Alcohol and/or Drug Treatment Records

□ Other: _____.

Purpose or Need for Release of Information (be specific):

□ Psychotherapy □ Protective Services □ Long Term Support
□ Case Management □ Medical Assistance Eligibility □ Court Investigations/Supervisions
□ Insurance Eligibility/Benefits □ Continuity & Coordination of Care □ Educational Planning □ Medical Care
□ Legal Investigation or Action □ Other:
_____.

I further understand the released information (verbal & written) may include diagnosis, prognosis, and/or treatment for physical, mental disorder, developmental disabilities, alcohol/drug abuse. I request information during the period of _____.

In contemplation of the above, and having read all of SIDE #2 of this form, I consent and authorize the release of information as described herein.

_____ _____ _____

Client or Participant / Legal Representative of Client or Participant ***Type of Relationship if Legal Representative*** ***Date***

SIDE #2

ADDITIONAL INFORMATION PERTAINING TO THIS AUTHORIZATION:

TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records which are protected by Federal Register 42 C.F.R. Part 2; 45 C.F.R. Parts 160-164; Wis. Stat. § 51.30; Wis. Stat. § 146.38; Wis. Stat. § 146.81 (2); and WI DHS Administrative Code Chapter 92. It may also be protected by other state and federal law. Unless you have other authorization, further disclosure of this information without the specific written consent of the client or his or her legal representative may be prohibited. A general authorization is not sufficient. Federal rules restrict any use of information received, related to this authorization, in criminal investigations and prosecutions.

TO THE CLIENT SIGNEE:

1. **Right to Refuse to Sign This Authorization**. Unless seeking eligibility in a benefit program or as a participant in a substances abuse program overseen by the courts, you are under no obligation to sign this form and your refusal will not affect the commencement, continuation or receipt of services you receive at Columbia County Health and Human Services. Those seeking enrollment in a benefit program or a program overseen by the courts may be denied the receipt of benefits or participation if eligibility cannot be established. A consequence of refusal to sign this authorization may also be nonpayment.
2. **Right to Revocation**. You have the right to revoke this authorization at any time by providing a written statement of withdrawal to the Columbia County Health and Human Services. However, your written revocation will not be effective until it is received by Columbia County Health and Human Services and will not be effective regarding the uses and/or disclosures of health/service information that Columbia County Health and Human Services has made prior to receipt of your withdrawal statement.
3. **Right to Receive a Copy of this Authorization**. If you agree to sign this Authorization, you must be provided with a signed copy of this form.
4. **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 except for records of medication and somatic treatment. This right may be denied by the treatment facility director, or his or her 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 Columbia County Health and Human Services. A uniform and reasonable fee may be charged for a copy of the records. The fee may be reduced or waived in accordance with agency policy for those clients who show an inability to pay. Wis. Stat. § 51.30(4)(d) and WI DHS Administrative Code § 92.03 through 92.06.
5. **Duration of Authorization**. This authorization will expire in one year from the date of signature unless otherwise specified: _____.
6. **Limitation**. Wisconsin law recognizes the need for informed consent in certain circumstances. The Authorization is limited to records dated up to and including the date specified by you on this form. A new Authorization will be necessary for releases of information on care provided after the date specified.
7. **Disclosure without Consent:** Regardless of your consent, there is no protection from nondisclosure if related to a crime committed on Columbia County property or for reports of suspected child abuse and/or neglect. In such circumstances, the proper authorities may be contacted.
8. **Re-release**. Once Columbia County Health and Human Services discloses your health/service information to the recipient, Columbia County Health and Human Services cannot guarantee that the recipient will not re-disclose health/services information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law. However, it is possible the recipient may be prohibited from disclosing certain information, such as that about substance abuse treatment and mental health.
9. **Improper Disclosure:** If you believe your health information was improperly disclosed, you may contact the following by mail: United States Attorney's Office, Western District of Wisconsin, 222 West Washington Avenue, Suite 700, Madison, WI 53703. If you wish to contact this office by telephone, they may be reached at (608) 264-5158 or TDD: (608) 264-5006.
10. **Copies**. A photocopy of this Authorization shall be considered as valid as the original**.**

☐ ***Place a check mark in the box and initial here _____ indicating you have read this page.***