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

1) **CLIENT INFORMATION (Please print):**

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

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

2) **PURPOSE OF DISCLOSURE (Select one):**

☐ Continuing Care ☐ Legal Matters ☐ Insurance/Eligibility/Benefits ☐ Personal Use – For me only, not to a third party
☐ Educational Planning ☐ Other: (Please specify): _____

3) **AUTHORIZES WCDHHS TO:** ☐ **DISCLOSE TO** ☐ **OBTAIN FROM (You may check both):**

Name of Individual/Agency/Organization/Other: _____

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

Method of Release:

☐ Electronic/Digital (specify) _____ Fax Number: _____
☐ US Mail ☐ 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	☐ Transportation Application
☐ Medical Eval/H & P	☐ Medications	☐ Access/CPS Reports	☐ Juvenile Records	☐ Geriatric Assessment
☐ Staffing/Progress Notes	☐ Psychological Eval	☐ Educational Records	☐ Public Health Records	☐ Nutrition Assessment
☐ Treatment Plan/Reviews	☐ Psychiatric Eval	☐ Financial Information	☐ Social History	☐ Daily Living Assessment
☐ Adult Human Services	☐ Laboratory Reports	☐ APS Abuse/Neglect	☐ Functional Screens	

☐ Other (Specify): _____

5) **SENSITIVE INFORMATION TO BE DISCLOSED: The law requires permission to release the following to a third party. Unchecked information cannot be released to anyone other than you personally.**

☐ Substance Use Disorder (SUD) ☐ Mental/Behavioral Health ☐ HIV/AIDS ☐ Developmental Disabilities ☐ Sexually Transmitted Infections

6) **DATE(S) OF INFORMATION TO BE DISCLOSED:**

☐ Start of services until one (1) year after date of last services. ☐ FROM: _____ TO: _____

7) **EXPIRATION:** Authorization valid until the following event/date: _____ or for up to one (1) year after date of last services.

YOUR RIGHTS: Right to Inspect/Receive a Copy of the Information to be Used or Disclosed: I understand I have the right to inspect or receive a copy of the information I authorized to be used or disclosed except for information not authorized by law. I may arrange to inspect or obtain copies by contacting WCDHHS. **I assume all risks of interception if I request to release my information in an unsecured manner.** Emails can be intercepted during transmission, and unencrypted messages, including attachments, can be read, copied, and forwarded. **I understand I may be charged a reasonable fee for record copies. Right to Receive a Copy of Authorization:** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a copy. **Right to Refuse to Sign Authorization:** I understand that I am under no obligation to sign this authorization and that WCDHHS may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision. **Right to Revoke this Authorization:** I understand that I may revoke this authorization at any time by providing written notification to WCDHHS Records or to the disclosing individual/organization. I can contact WCDHHS Records by email at HHSRecordsRequest@Waukeshacounty.gov or by writing to: Waukesha County Department of Health and Human Services, Attention: Centralized Records, 514 Riverview Ave. Waukesha, WI 53188. I understand that my revocation WILL NOT apply to uses and/or disclosures 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 that may be needed for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage. Disclosures to persons within the criminal justice system who made participation in a SUD program a condition of the disposition of any criminal proceedings may not be revoked until the final disposition of the conditional release or other action for which the consent was given. ****WI Statute 252.15 and 42 CFR Part 2** require client authorization to disclose health information for payment purposes. A consequence of refusal to sign an authorization for disclosure pursuant to WI Statute 252.15 or 42 CFR Part 2 records may be non-payment by insurance. ****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:** 42 CFR part 2 prohibits unauthorized use or disclosure of these records. I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws. The third party may not be required to abide by this authorization or applicable laws governing use and disclosure of my health or confidential information. This information has been disclosed from records protected by Federal and State confidentiality rules. The Federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any substance use disorder client. **A copy or fax of this authorization is considered valid as the original and must be sent with all Part 2 Disclosures.**

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

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

10) **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. (e.g., Guardianship Papers, Power of Attorney documents)**

For Office Use Only: *Workforce member assisting client with completion of authorization:* _____