Behavioral Health

WOOD COUNTY HUMAN SERVICES DEPARTMENT

Authorization for Use or Disclosure of Protected Health Information

Name of Client: _____ DOB: _____

I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

I authorize Wood County Human Services, 111 West Jackson Street, Wisconsin Rapids, WI 54495 to:

☒ **Disclose Information To:** ☒ **Receive Information From:** ☐ **Exchange Information With**

Name: Wood County Adult Drug Court Treatment Team
Address: 400 Market Street
City, State & Zip: Wisconsin Rapids, WI 54494
Phone Number: _____
Fax Number: _____

I hereby authorize the release of the information checked and/or listed below for the time period beginning on _____ and ending on _____.

- ☒ Disclosure of Presence, appointment & counselors
- ☐ Mental Health Intake/Progress Notes
- ☒ AODA Intake/Progress Notes/OWI Assess/Eval
- ☐ Psychiatric/Psychological Testing
- ☐ Inpatient Hospitalization Records
- ☐ Medical History/Medical History
- ☐ Lab Results
- ☐ School and/or Employment
- ☐ Discharge Summary/After-care plan
- ☒ Legal History
- ☐ Background/Social History
- ☐ Academic Records/Progress
- ☒ Telephone Contact/Consultation
- ☐ Treatment Plan
- ☐ Permission to Audio/Video tape session
- ☐ Other: _____
- ☐ Other: _____

Purpose for Disclosure: ☐ Further Medical Care ☐ Personal Use ☐ Legal Issue

☒ Continuity of Beneficial Care ☐ Payment/Insurance ☐ Other (please describe): _____.

I understand that records are protected under the State Administrative Code, DHS 92, and federal regulations governing Confidentiality of Alcohol & Drug Abuse Patient Records, 42 CFR, part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that information may be disclosed as outlined in Wisconsin Statute 961.385 Prescription drug monitoring program.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.

I hereby release Wood County, its employees, officers, and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke this request at any time by providing Wood County with my written notice of such revocation. A photo static copy or fax of this original and/or revocation shall be considered as valid as the original.

This authorization will remain in effect from the date this authorization is signed until the _____ day of _____, 20_____ or a period of one year from the date this authorization was signed if not specified.

By signing this, you specifically authorize the use and disclosure of the information you selected above. You acknowledge that you have reviewed and understand this authorization form.

Date: _____ Signature of Client: _____
Printed Name of Client: _____
Date: _____ Signature of Representative: _____
Printed Name of Representative: _____
Relationship to Client: _____

A copy of this record must be provided to the person making the request and a copy must be filed in the medical record.
Rev 2/18