ROCK COUNTY HUMAN SERVICES DEPARTMENT
Behavioral Health Division

ADMISSION CONSENT FOR INFORMATION RELEASE

Client Name ___________________________________ Client Date of Birth _______________

I hereby authorize the Behavioral Health Division programs of the Rock County Human Services Department to release information as described on this form. This authorization is given voluntarily, and I have been informed of, and understand, the following:

BE SURE EVERY SECTION IS MARKED YES OR NO BEFORE YOU SIGN THIS FORM

✓ YES OR NO	IF YES IS MARKED, YOU MAY RELEASE INFORMATION TO:	PURPOSE AND DESCRIPTION OF INFORMATION TO BE RELEASED
☐ **Yes** ☐ **No**	**Phone Calls and Messages**	Information regarding appointments, instructions, and safety concerns may be left on voicemail or with whoever answers at the phone numbers that have been provided on my account, including parents and/or guardians. This includes welfare checks and automated reminder calls.
☐ **Yes** ☐ **No**	**Pharmacies and Related Prescription-processing companies**	Name, address, date of birth, social security number, gender, medical record number, name of medication and associated diagnoses required when sending prescriptions or prior authorizations to the pharmacy that has been identified for this client's medications.
☐ **Yes** ☐ **No**	**Transportation Services**	Name, address, diagnoses, date of birth, social security number, and related medical difficulties required to arrange for transport and related billing procedures.
☐ **Yes** ☐ **No**	**Patient Assistance Program**	Diagnoses, earned/unearned income, living arrangements and other information needed to arrange for discounted medications through the program.

REVOCATION & EXPIRATION OF CONSENT: I understand that this consent can be withdrawn by me in writing at any time except to the extent that action has already been taken in reliance thereon. To revoke authorization, please send a request in writing to Medical Records Department, P.O. Box 1649, Janesville, WI 53547. Unless revoked earlier, or otherwise specified below, this consent will expire in twelve (12) months from the date signed. If desired, specify another expiration date. _____/_____/_____

CONSENT: I hereby consent to and authorize the release of information as described on this form. I may also receive a copy of this consent form. The client or person authorized has a right to inspect and, upon payment of usual fee, receive a copy of the material to be disclosed. I understand that I am under no obligation to sign this form and that treatment will not be denied if I refuse to sign this authorization. WI Statutes 51.30 and 252.15 require patient authorization to disclose health information for payment purposes. **The recipient of the records may re-disclose the information that I authorize to be released only if allowed by law.** Records may be released from the signature date of this authorization forward, until the expiration of this authorization. I understand that information disclosed as a result of this authorization may no longer be subject to protection by federal privacy standards.

Client Signature ____ Date ____________________

Parent/Guardian Signature _______________________________ Date ____________________

Staff Signature ____ Date ____________________