ROCK COUNTY HUMAN SERVICES DEPARTMENT
MEDICAL RECORDS
P.O. BOX 1649, 3530 N. COUNTY TRUNK F
JANESVILLE, WISCONSIN 53547-1649

Please make sure that the Rock County Human Services Confidential Information Release Authorization form includes the following information when requesting records:

Element	Description and Guidelines

Client Name (also include birth date to assure proper identification). Include maiden names and other names.
If you are requesting Child Protective Services records, please enter the name/s of your child/ren in this field.

1 Information From (Individual/Agency Making the Disclosure): Name and address of provider/facility you are authorizing to release the information. It can be all of the Human Services Department or a specific program (e.g., Child Protective Services, Outpatient Counseling Center, etc.).

2 Information To (Recipient of the Information): Name and address of individual/provider/requestor authorized to receive the information **AND** how you would like to receive your records (mail, email, fax, pick-up) including **phone number,** mailing address, fax number or email address.

3 Two-Way Exchange of Information: Mark Yes if you want information released to and from both parties (e.g., between providers). If the field is left blank then the answer defaults to No.

4 Purpose/Reason for the Disclosure: Indicate why the information is being sent or requested.

5 Specific Information to be Disclosed: Mark all types of information that apply. Please check both Substance Abuse records and Mental Health records categories if you are receiving Behavioral Health services to ensure any AODA assessments, etc., completed during the course of treatment can be released.

6 Expiration of this consent: Describe the condition or specify a date of time period for the consent. The consent should be valid for a reasonable period of time so that the purpose can be accomplished. The consent expires in twelve months if a different date is not entered.

Client Signature: Signature of client (if client is a minor or has a guardian please sign in Person Authorized by Client space)

Person Authorized by Client: Signature of parent/guardian/legal representative. (Proof of representation for guardian/legal representative must be submitted with authorization.

Expiration of this consent: Describe the condition or specify a date of time period for the consent. The consent should be valid for a reasonable period of time so that the purpose can be accomplished. The consent expires in twelve months if a different date is not entered.

Date: Date signed by client or parent/guardian/legal representative.

Witness Signature. Witness signature is required for many out-of-state requests but not if providers are located in Wisconsin.

*If the authorization does not include all of the above items, it will be returned and your request will be delayed.