

**CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION**

Client Name	Maiden/Other	DOB									
<b>1</b> Info. From (Individual/ Agency Making Disclosure)	<input type="checkbox"/> <u>Rock County Human Services Dept.</u> ; Program: _____ P.O. Box 1649, Janesville, WI 53547  <input type="checkbox"/> Other Individual/Agency (Enter name and address) _____										
<b>2</b> Information To (Recipient of Information)	<input type="checkbox"/> <u>Rock County Human Services Dept.</u> ; Program: _____ P.O. Box 1649, Janesville, WI 53547  <input type="checkbox"/> Beloit Memorial Hospital, 1969 West Hart Road, Beloit, WI 53511 <input type="checkbox"/> Mercy Health System, 1000 Mineral Point, Janesville, WI 53545 <input type="checkbox"/> Rock County Sheriff's Office, 200 Highway 14 East, Janesville, WI 53545 <input type="checkbox"/> UW Hospital & Clinics, Madison, WI <input type="checkbox"/> Other Individual/Agency (Enter name, email and/or address) _____										
<b>3</b> Two-Way Exchange	I authorize this information to be released <b>between</b> the designated organizations (mark one). <input type="checkbox"/> Yes <input type="checkbox"/> No										
<b>4</b> Purpose/ Reason (may leave blank)	<table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Benefit Determination</td> <td><input type="checkbox"/> Disability Determination</td> <td><input type="checkbox"/> Provider Licensing/Certifying</td> </tr> <tr> <td><input type="checkbox"/> Child Custody Case</td> <td><input type="checkbox"/> Driver's License Determination</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Coordinate Care and Services</td> <td><input type="checkbox"/> Insurance Claim</td> <td>_____</td> </tr> </table>		<input type="checkbox"/> Benefit Determination	<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Provider Licensing/Certifying	<input type="checkbox"/> Child Custody Case	<input type="checkbox"/> Driver's License Determination	<input type="checkbox"/> Other _____	<input type="checkbox"/> Coordinate Care and Services	<input type="checkbox"/> Insurance Claim	_____
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<b>5</b> Specific Information to be Released	<input type="checkbox"/> Substance abuse records including screening, assessment, diagnoses, treatment plan and recommendations, ASAM, and Discharge Summary. This includes information pertaining to future treatment. <input type="checkbox"/> Drug Test Results <input type="checkbox"/> Mental health, psychiatric services, developmental disability records. This includes information pertaining to future treatment. <input type="checkbox"/> Child Protective Services Records <input type="checkbox"/> Juvenile Justice Records <input type="checkbox"/> Including re-disclosure of (describe type of records) _____ from (name of treatment facility/other agency) _____ in our possession. <input type="checkbox"/> Other (Describe/specify) _____										
<b>6</b> 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 contact the Individual/Agency Making Disclosure (listed in section 1 above AND/OR section 2 when section 3 is marked Yes). If Rock County Human Services Department, please speak with your case manager or call the Medical Records Department at 608-757-5448. 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. ____ / ____ / ____										
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. <b>The recipient of the records may re-disclose the information that I authorize to be released only if allowed by law.</b> 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									
Signature of Parent/Legal Guardian/POA/Other		Relationship to Client									
Witness Signature											