WALWORTH COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I, _____, Date of Birth _____, authorize disclosure between:
Name of consumer or individual

Walworth County Department of Health and Human Services
W4051 County Rd NN, PO Box 1005
Elkhorn, WI 53121

❒ TO RELEASE TO
❒ TO RECEIVE FROM
❒ TO RELEASE TO AND FROM

_____
_____
_____

The disclosure of the following specific information is authorized. NOTE: Separate authorizations are necessary for the disclosure of psychotherapy notes and HIV communicable disease disclosures.

❒Psychosocial History ❒Psychiatric Evaluation ❒Psychological Evaluation ❒Treatment Schedule/Plan
❒Treatment/Case Notes ❒Physician's Orders ❒Physical Examination ❒Discharge Summary
❒Lab Data/x-ray ❒Alcohol/Drug Abuse ❒Assessments(be specific)_____
❒Information from other agencies (be specific) _____
❒Other (be specific)_____

The Purpose of this Disclosure is:

❒ Further Medical Care ❒ Insurance Eligibility/Benefits ❒Personal ❒Changing Physicians
❒Legal Investigation or Action ❒ At the Request of the Individual ❒Other _____

NOTICE: YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Receive a Copy of this Authorization
I understand that once I sign this Authorization, which I am not required to do, I will be provided with a copy of the signed form.

Right to Refuse to Sign this Authorization
I understand that I may refuse to sign this authorization. I understand that Walworth County Department of Health and Human Services will not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign or refuse to sign this authorization. Walworth County Department of Health and Human Services may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of a valid authorization for the disclosure of the protected health information to a third party.

Right to Revoke this Authorization
I understand that I may revoke this authorization except to the extent that action has been taken in reliance on it. I understand that written notification is necessary to withdraw this authorization. The procedure to revoke this authorization is found in Walworth County Department of Health and Human Service's Privacy Notice, or if you need assistance you may contact the Privacy Officer at 262-741-3200.

Right to Know the Potential for Re-disclosure
I understand that once information is disclosed pursuant to this signed authorization, federal privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information, therefore may not prohibit the recipient from re-disclosing it without my authorization.

The following notice shall accompany all disclosed information regarding drug and alcohol abuse consumers: "This information has been disclosed to you from records protected by federal confidentiality rules (*42 CFR part 2*). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is *NOT* sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65." The patient has the right of access to medical record information as provided under DHS 92.05 and 92.06.

This authorization shall expire 1(one) year from the date it is signed, or on the following date _____, or event_____, whichever is earlier.

SIGNATURES

_____ Date:_____
Signature of consumer (Minors included)

_____ Date:_____
Signature of legally responsible person or personal representative (if required)

Please explain representative's authority to act on behalf of consumer:_____