

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
 1910 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.

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

The Purpose of this Disclosure is:

- | | | | |
|--|---|--------------------------------------|--|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Personal | <input type="checkbox"/> Changing Physicians |
| <input type="checkbox"/> Legal Investigation or Action | <input type="checkbox"/> At the Request of the Individual | <input type="checkbox"/> 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

 Signature of consumer (Minors included) Date: _____

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

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