RICHLAND COUNTY HEALTH AND HUMAN SERVICES

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH OR CONFIDENTIAL INFORMATION

_____	_____	_____
Name of Individual/Previous Names	Birth Date	Social Security No.

AUTHORIZES:

Richland County Health & Human Services

TO EXCHANGE _____ RELEASE TO _____ OR RECEIVE PROTECTED HEALTH OR CONFIDENTIAL INFORMATION FROM _____:

_____	_____
Agency/unit	Individual/agency/organization
_____	_____
Street Address **Richland Center, Wisconsin 53581**	Street Address
_____	_____
City, State, Zip Code **(608) 647-**	City, State, Zip Code
_____	_____
Phone/Fax	Phone/Fax

INFORMATION TO BE RELEASED:

Information to be released may be in Written, Verbal, Voice Mail, Fax, or Electronic Form

____Initial Assessment	____Mental Health Records	____ Early Intervention Records
____Educational Records	____Psychological Evaluation	____ Multidisciplinary Team Evaluations
____Progress Notes	____Psychiatric Evaluation	____ Medical Records
____AODA Records	____ESS Records	____ Individualized Family Service Plan
____Case Plans/Evaluations	____Permanency Plans	____ Family & Safety Assessment
____ Financial Information	____Other (Specify): _____	

Records to be disclosed are between the dates of _____and _____.

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

____Continuity of Care	____Insurance/Eligibility/Benefits	____Further Medical Care
____Educational Planning	____Legal Investigation or Action	____Personal
____Changing Providers	____Coordination of Services	____Evaluate & Plan an Individualized Program

____Other (Specify): _____

I have reviewed and understand my rights, which are printed on the back of this form.

_____	_____
(Client Signature)	(Date of Client or Authorized Signature)
_____	_____
(Other Authorized Signature*)	(Witness Signature)

*Legally authorized because client is: ___Minor** ___Incompetent ___Unable to sign due to disability ___Deceased
Legal Authority: ___Parent of Minor ___Legal Guardian/Representative ___Spouse
**See explanation of Clients younger than 18 years old described above.

All persons signing for release of records instead of the client must state their relationship to the client and have available proof of legal authority prior to the release of the records.

_____

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL

EXPIRATION DATE: This authorization is good until the following: the completion of active services, the following date: _____, or one year from the date signed, unless a written notice of revocation is submitted. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Richland County Health and Human Services. The revocation will be effective immediately upon Richland County Health and Human Services' receipt of my written notice, except that the revocation will not have any effect on any action taken by Richland County Health and Human Services in reliance on this Authorization before Richland County Health and Human Services received my written notice of revocation.

ACTION NEEDED: ___Send Records ___Send For Records ___Send Authorization Only ___No Action Needed

RETURN COMPLETED FORM TO:_____

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records, which are protected by Federal Register "42 C.F.R. Part II"; "45 C.F.R. Parts 160-164"; Wis. Stats. § 51.30; Wis. Stats. § 146.38; Wis. Stats. § 146.81(2); and Chapter HFS 92 of the Wisconsin Administrative Code. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without specific written consent of the client or their legal representative.

RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION - I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of services I receive at Richland County Health and Human Services; except however, if my services at Richland County Health and Human Services are for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Richland County Health and Human Services may refuse to provide services to me if I do not sign this Authorization

RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION – I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form.

RIGHT TO INSPECT OR COPY THE HEALTH OR CONFIDENTIAL INFORMATION TO BE USED OR DISCLOSED – I understand that I have a right to inspect or copy the health or confidential information I have authorized to be used or disclosed by this Authorization form, except for records of medication and somatic treatment. This right may be denied by the treatment facility director, or designee, during the client's treatment under certain circumstances. I may arrange to inspect my health or confidential information or obtain copies of my health or confidential information by contacting Richland County Health and Human Services.

A uniform and reasonable fee may be charged for a copy of the records, which fee may be reduced or waived in accordance with agency policy for those clients who show an inability to pay. Section 51.30(4)(d), Wisconsin Statutes, and Sections HSS 92.03(3)(d), 92.05, and 92.06, Wisconsin Administrative Code.

Wisconsin Statutes recognizes the need for informed consent in certain circumstances. The Authorization is limited to records dated up to and including the date specified by the client on this form. A new Authorization will be necessary for releases of information on care provided after the date specified by the client.

All clients 18 years of age and older must sign for the release of their own health records, unless one or more of the following conditions apply:

a. Client is incompetent
b. Client is disabled and cannot sign the form
c. Client is deceased (the surviving spouse or legal representative must sign authorization releasing records of deceased client).

Clients younger than 18 year:

a. Treatment for drug and alcohol abuse: Information from a minor's alcohol or drug abuse treatment can only be released with the consent of both the minor and their parent, guardian, or person in the place of the parent, except that outpatient or detoxification services information can be disclosed with only the minor's consent as long as the minor is at least 12 years old.

b. Treatment for mental health issues: A minor who is 14 years or older can consent to release of information without the consent of their parent, guardian, or person in place of a parent, as long as they are capable of providing informed written consent.

I understand that once Richland County Health & Human Services discloses my health or confidential information to the recipient, Richland County Health & Human Services cannot guarantee that the recipient will not redisclose my health or confidential information to a third party, which could result in my health and confidential information no longer being protected. The third party may not be required to abide by this Authorization or applicable Federal and State law governing the use and disclosure of my health or confidential information

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I hereby, knowingly and voluntarily, authorize Richland County Health and Human Services to use or disclose my health or confidential information in the manner described in this Authorization. I understand that additional information regarding Richland County Health and Human Services Privacy Practices is included in Richland County Health and Human Services' Notice of Privacy Practices.