SHEBOYGAN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
Authorization for Release of Confidential Information and Protected Health Information

Client Name | Client DOB

Street Address | City, State, Zip | Telephone Number

2. AUTHORIZES:

☒ Release to:
☒ Obtain from

Sheboygan County Department of Health and Human Services – Treatment Court
1011 North Eighth Street
Sheboygan, WI 53081

☒ Release to:
☒ Obtain from

Name
Treatment Court Team
Organization
1011 North 8th Street
Address
Sheboygan, WI 53081
City, State, ZIP Code

I authorize the above-named agencies/individuals to communicate and exchange ☐ written ☐ verbal ☐ written and verbal information regarding treatment. I agree to pay a uniform charge for reproduction which may be assessed. I understand that subunits of the Department which are subject to HIPAA may exchange confidential information about a client, internally, and with any treatment providers who have a service contract with the Department if such information is necessary to enable an employee or service provider to do his or her job or to enable the Department to coordinate services for the client.

Information may be released for the following date(s): From: _____ To: _____
This authorization is good until the following date or event: _____
_____ (or one year from signature date)

3. INFORMATION TO BE RELEASED: (client please initial on line)

PHI
☒ ____ Diagnosis
☒ ____ Discharge Report
☐ ____ Guardianship Records
☒ ____ History and Physical
☐ ____ HIV/AIDS Status
☐ ____ Immunizations
☒ ____ Intake/Initial Assessment
☒ ____ Laboratory Results
☒ ____ Test Results
☒ ____ Progress Notes
☒ ____ Psychiatric Records/Notes

PHI
☒ ____ Psychological Evaluations
☒ ____ Treatment/Care Plan
☒ ____ Substance Abuse Assmnt/Diag
☒ ____ Substance Abuse Disch Summ
☒ ____ Substance Abuse Progress Notes
☒ ____ Substance Abuse Treatment
☐ ____ X-Ray/Ultrasound Report
☒ ____ Group Therapy Notes
☐ ____ Public Health Screening/Service Records

Non-PHI
☐ ____ Child Abuse/Neglect Reports
☒ ____ Financial Information
☒ ____ Residential Records
☒ ____ School Academic Records
☐ ____ School Attendance Records
☐ ____ School Behavior Records
☐ ____ School Pupil Service Records
☒ ____ Vocational Records
☒ ____ Law Enforcement Records
☒ ____ Court Records
☒ ____ Other – Specify: Any Information needed to coordinate care

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

☐ _____ Mental Health
☒ _____ Drug/Other Substance Abuse
☐ _____ Other (specify): _____
☐ _____ Developmental Disabilities
☐ _____ HIV/AIDS
☐ _____ Alcoholism
☐ _____ Sexually Transmitted Diseases

4. PURPOSE OF DISCLOSURE: (Check applicable categories)

☐ _____ Continuing Care ☐ _____ Personal ☒ _____ Other ☐ _____ Discuss Case Specifics

5. REDISCLOSURE NOTICE:

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization might no longer be protected by the federal privacy standards, and my health information might be redisclosed without obtaining my authorization.

6. Your Rights with Respect to This Authorization:

Right to Receive a Copy of This Authorization – I understand that I have a right to receive a copy of this authorization.

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

Right to Revoke This Authorization – I understand that I have a right to revoke this authorization at any time by providing a written statement of revocation to the Privacy Officer at the Department of Health and Human Services, 1011 North Eighth Street, Sheboygan, WI 53081. I am aware that my revocation will not be effective until received and will not be effective regarding the uses and/or disclosures of my health information that Sheboygan County Health and Human Services Department has made prior to receipt of my revocation. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Right to Inspect of Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Officer at the Department of Health and Human Services, 1011 North Eighth Street, Sheboygan, WI 53081.

HIV Test Results – I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

Re-disclosure Notice – I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

7. Disclosure of Direct or Indirect Payment Received by Any Person or Organization Authorized to Use or Disclose my Health Information:

I understand that Sheboygan County Department of Health and Human Services will not be receiving any direct or indirect payment in connection with the use or disclosure of my health information other than the uniform charge referred to above.

8. Note to the Information Recipient if You Receive Alcohol and Drug Abuse Patient Records:

This information has been disclosed to you from records which may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. Failure to sign this release will not jeopardize WIC Program eligibility or participation.

Signature: _____ Date: _____

If signed by person other than client, state relationship and authority to do so. _____

_____

Client Name: _____

Client is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased ☐ Self

Legal Authority:
☐ Custodial Parent
☐ Legal Guardian
☐ Personal Representative of Estate of Deceased
☐ Authorized Legal Representative
☐ Power of Attorney for Healthcare
☐ Self

A PHOTOCOPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL