CONSENT TO DISCLOSE CONFIDENTIAL INFORMATION

Patient Name: ______________________________ **Birth Date**: ________________ **Phone**: __________________

____
Address **City** **State** **Zip**

Authorizes:
St. Croix County Dept. of Health & Human Services 1752 Dorset Lane, New Richmond, WI 54017
Individual Requesting Records:____
To: ☐ Release to: ☐ Receive from: ☐ Verbally exchange with:

Individual/Organization ____

____
Address City/State/Zip Phone Fax

All my treating providers from____

____
Address City/State/Zip Phone Fax

All my non-treating providers from____

____
Address City/State/Zip Phone Fax

In compliance with WI Statutes and federal regulations which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Mental Health ☐ Substance Use Disorder ☐ HIV ☐ Juvenile Supervision
☐ Sexually Transmitted Disease ☐ Developmental Disabilities ☐Physical Disabilities ☐Child Protection Services
☐Other (specify)_________________________

Information to be released: (check all that apply)

☐ Discharge and Closing Summaries
☐ Prescription for Treatment
☐ Progress Reports/Case Notes
☐ Psychiatric Evaluations (include diagnosis/prognosis)
☐ Medical Reports/Physical Exams
☐ Therapy Progress Reports
 ☐Speech ☐ OT ☐ PT
☐ Chemical History/Assessment
☐ Admission History and Evaluations/Assessments
☐ Treatment Plans/Agreements
☐ Contracted Agency Discharge/assessment
☐ Court Reports/Custody Studies
☐Psychological Tests/Evaluations
☐ CPS Reports
☐ Social History
☐ Lab Reports
☐ Aftercare Plans
☐Vocational Eval Reports
☐School Records
☐Other(specify)____

For the following dates: From ______________________________ **to** ______________________________

The specific purpose or need for such disclosure is: (check all that apply)
☐ Coordination of Care ☐ Obtain History ☐ Human Services investigation ☐ Other (specify) ____________________

This authorization will be effective for medical/treatment records generated to the date of signature, and the release of medical records created after the date of signature until the expiration date or the release is revoked by me in writing. This authorization for disclosure of information has been fully explained to me and I understand it. I have been offered a copy of this form. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires within one year of the signing of this form, or (specify date/event) ____________ __________. I understand that I am under no obligation to sign this form and that the person and/or agency listed above who 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. The consent will last no longer than reasonably necessary to serve the purpose for which it is given. The information disclosed is restricted to the minimum amount necessary to accomplish the intended purpose. The information used or disclosed may no longer be protected once it is used or disclosed in accordance with this authorization. A copy of this consent has the same force and effect as the original. By signing this authorization, I am confirming that I have had an opportunity to review and understand the content of this authorization form and that it accurately reflects my wishes. **I AM ALSO CONFIRMING THAT I HAVE READ AND UNDERSTAND THE RIGHTS WITH RESPECT TO THIS AUTHORIZATION, WHICH ARE LOCATED ON THE BACK OF THIS AUTHORIZATION FORM.**

Signature of Client: ____ Date: ____________________
Signature of Guardian/Legal Rep: ______________________________ Date: ____________________
If signed by a person other than the patient, complete the following:

1. Client is: ☐ Minor ☐ Incompetent ☐ Unable to sign due to disability ☐ Deceased
2. Legal Authority: ☐ Parent of Minor ☐ Legal Guardian/Representative

** All persons signing for the release of records instead of the client must state their relationship to the client and have proof of legal authority attached to this authorization before we will release any records. (i.e. Guardianship Papers)**

ADDITIONAL INFORMATION REGARDING THE USE & DISCLOSURE OF YOUR HEALTH/CONFIDENTIAL INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- **Right to Inspect or Copy the Confidential Information to be Used or Disclosed:** I understand that I have the right to inspect or copy the health of confidential information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health or confidential information or obtain copies of my confidential information by contacting St. Croix County Department of Health & Human Services Medical Records Department.
- **I understand that I may be charged a fee for record copies.**
- **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 Refuse to Sign this Authorization:** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed who 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.
- **Right to Revoke this Authorization:** I understand that I can cancel this authorization at any time by providing a written notification to the Privacy Officer at St. Croix County Department of Health & Human Services or to the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this Authorization before receipt of the written notice of revocation; or needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage.
- **Re-disclosure Notice:** I understand that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. 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 understand that a copy of this authorization will be considered valid as the original.**
- **Note to Disclosing Party:** As a public agency, the St. Croix County Department of Health & Human Services is governed by the Wisconsin Open Records Law. Information the Department receives in effect becomes part of the client's record, just as if it were created by the Department. A "confidential" label on a record is not sufficient to restrict client access or re-release. It can only be protected by a specific confidentiality law, Section 19.85 (Wisconsin Statutes), or the balancing test in the Open Records Law.
- **These restrictions** on disclosure do not apply to communications of information between or among St. Croix County Department of Health & Human Services personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse.
- **I understand** that my Substance Use Disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2 , and Health Insurance Portability and Accountability act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Updated April 2019