Health & Human Services
1752 Dorset Lane | New Richmond WI 54017
Telephone: 715-246-8314 | Fax: 715-246-8338

Release of Information

Client Name: _____ Date of Birth: _____

Previous Names: _____ Phone: _____

Mailing Address: _____

I authorize St. Croix County Health & Human Services (specify division if applicable) _____
to (check all that apply) ☐ **verbally communicate with:** ☐ **receive records from:** ☐ **release records to:**
☐ Individual/Organization: ☐ All my Treating Providers from: ☐ All my Non-Treating Providers from:

Name: _____ Phone: _____

Address: _____ Fax: _____

How would you like the records sent/received? ☐ Fax ☐ Mail ☐ Pick Up
☐ Email: _____

For the Purpose of: (check at least one)
☐ Coordination of Care ☐ Obtain History ☐ Legal ☐ Other: _____

Release Records Pertaining to: (check at least one or all that apply)
☐ Mental Health ☐ Youth Justice ☐ Sexually Transmitted Disease
☐ Substance Use Disorder ☐ Jail Services ☐ Developmental/Physical Disabilities
☐ Child Protection ☐ HIV ☐ Other: _____

Records to be Released: (check at least one or all that apply) ☐ Not Applicable
☐ Admission History/Integrated Assessment ☐ Psychiatric Evaluation ☐ CPS Reports ☐ Vocational Evaluations
☐ Prescription for Treatment ☐ Treatment Plans ☐ Lab Reports ☐ Discharge Summaries
☐ Progress/Case Notes ☐ School Records ☐ Social History
☐ Psychological Eval/Tests ☐ Therapy Records: ☐ Speech ☐ OT ☐ PT
☐ Other: _____

Date Range of Records Being Requested: From: _____ To: _____

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 authorization at any time except to the extent that action has been taken in reliance on it and that in any event this authorization expires within one year of the signing of this form or (specify date) _____. 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. This authorization 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 authorization 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 it accurately reflects my wishes.

Client Signature: _____ **Date:** _____

Legal Representative Signature: _____ **Date:** _____

Relationship to Client: _____
All persons signing for the release of records on behalf of the client, must state their relationship to the client and provide proof of legal authority (i.e. Guardianship papers, Power of Attorney for Health Care, etc.).

For Internal Use Only
St Croix County staff requesting records: _____

Additional Information Regarding the Use & Disclosure of Your Protected Health 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 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 disc losing 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 Authorizations 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.

- **Redisclosure Notice**: I understand that the information used and/or disclosed pursuant to this Authorization may be subject to redisclosure 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 and 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.