MONROE COUNTY DEPARTMENT OF HUMAN SERVICES

210 W Oak St Sparta, WI 54656-4509

PHONE: (608) 269-8600 FAX: (608) 269-8935

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(PLEASE COMPLETE IN FULL)

Name – Last, First, MI _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Social Security Number _____ Client ID No. _____

Monroe County Department of Human Services:

Releases Information TO:
Staff Person/Program: _____
Agency: _____
Address: _____
Phone: _____ **Fax:** _____

Receives Information FROM:
Staff Person/Program: _____
Agency: _____
Address: _____
Phone: _____ **Fax:** _____

Method of Exchange: (Check all that apply.) ☐ One-way disclosure ☐ Reciprocal (two-way) disclosure ☐ Ongoing Exchange ☐ Verbal ☐ Written

Type of Records: (Check all that apply.) ☐Alcohol/Drug ☐Drug Court ☐Mental Health ☐Child/Family ☐Adult/Elderly ☐Birth-3 ☐Alternate Care

Purpose of Disclosure: (Check all that apply.)

☐ medical care
☐ legal investigation/action
☐ counseling/therapy
☐ educational planning
☐ care continuity/coordination
☐ disability determination
☐ insurance application
☐ payment of claim
☐ placements
☐ other_____

Information to be Disclosed: (Check all that apply and specify dates or time frames when known.)
Information being requested is from _____ to _____

☐ Intake/Initial Assessment
☐ Social Service/Worker Records
☐ Psychiatric/Psychological Evals
☐ Treatment Plans/Reviews
☐ AODA Treatment Records
☐ Medical/Diagnostic Records/Lab
☐ Staffing/Progress Notes
☐ Discharge Summary
☐ Hospitalization Records
☐ AIDS/HIV Testing Results
☐ Law Enforcement Records
☐ Child Protective Service Reports
☐ Court Reports/Records
☐ Custody Study Reports
☐ School Evaluations/Records
☐ Multi-disciplinary/IEP Reports
☐ Individualized Family Service Plans
☐ Other:_____

I understand that my records are protected under federal and state laws and administrative codes, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. By signing this authorization, I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on signing this authorization. I understand that I have a right to inspect and receive a copy of any written material to be disclosed. Copies of records may be obtained with reasonable notice and payment of copying costs. When this information is used or disclosed by the authorized recipient, the information may be subject to re-disclosure and is no longer protected. This authorization may be revoked at any time in writing prior to the disclosure of this information. This authorization will expire twelve (12) months from the date signed unless specified with an alternate date and reason.
Date:_____ Reason/Condition:_____

Signature of Client/Legal Representative:_____ Date:_____
(If signed by person other than client, state relationship and authority to do so.)
Client is: ☐ minor ☐ incompetent ☐ incapacitated ☐ deceased **Legal Authority:** ☐ legal guardian ☐ health care agent ☐ biological parent of minor ☐ spouse/personal rep. of deceased ☐ Other:_____

Signature of Witness: _____ Date:_____