# AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

**Jackson County Department of Health & Human Services – Behavioral Health Services**

421 County Rd R, Black River Falls, WI 54615
Telephone: (715) 284-4301 Fax: 715-284-7713

I, ______________________________________________________Birth Date:________________

Authorize ________________________________________________________________________
(Name, address, contact number, fax number of person or program)

________________________________________________________________________

disclose to receive from exchange with

**Jackson County Department of Health & Human Services – Behavioral Health Services**

The following specific information from my records (check all that apply):

Verbal and Written
Progress Intake
Summary Discharge
Summary Treatment Plan
Referral Outcome

Psychological Evaluation
Psychiatric Evaluation
Medical Evaluation/Records

Social History
Medications
School Records

Substance Use Information, Consultation, Correspondence

Others (please state) ______________________________________________________________

The purpose of disclosure is:

Diagnostic evaluation and/or consultation
Coordination of care
Treatment planning
The request of the individual
Other ______________________________________________

I understand that records/information related to my treatment may be released only upon my written consent, or as otherwise specified by law. I understand that I have a right to inspect and upon paying applicable fees, receive a copy of the material to be disclosed as required under §§ HFS 92.03-51.30 Wis. Status. Except for medications and somatic treatment records, the facility treatment director or designee may deny the right during treatment in some circumstances. I understand that I am under no obligation to sign this form and that treatment services are not contingent upon my decision concerning release of information. I may revoke this authorization at any time in writing except to the extent that information already released pursuant to this authorization cannot be recalled. A photocopy of this authorization shall be considered as valid as the original, and shall be maintained in the record and provided to me. Note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Privacy Rule. I have a right to receive a copy of this authorization.

By checking this box I authorize the release of medical information created before and after the date of my signature.
This authorization will remain in effect for ongoing exchange of information until: ____________
This authorization will be effective for client/patient records generated to the date of signature.

______________________________________________________________________________
Signature of Client/Patient (or individual authorized to consent) Date

______________________________________________________________________________
Signature of Witness Date

Client/Patient is :☐ minor ☐ legally incompetent ☐ deceased