JACKSON COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

Authorization for Disclosure of Health Information and Confidential Information

Consumer Name: _____ Birthdate: _____

Street Address: _____ City, State, Zip: _____

Authorizes:
Jackson County Department of Health and Human Services
421 County Road R
Black River Falls, WI 54615

The following authority regarding my protected health information and other confidential information:
☒ To release ☒ To receive ☒ To verbally exchange with

_____
Name of Healthcare Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

Information to be released: (Check all that apply)

- ☐ Medical history, examination, reports
- ☐ Diagnosis/Client History
- ☐ Progress notes
- ☐ Treatment plan
- ☐ Medications
- ☐ Discharge Summary
- ☐ Aftercare Plan
- ☐ Lab reports
- ☐ School Records
- ☐ Voc Eval Report
- ☐ Restorative Justice
- ☐ Law Enforcement Records
- ☐ Child Advocacy Team
- ☐ Protective Service Narrative/Human Services Reviews
- ☐ Therapy Progress Reports: ☐ Speech; ☐ OT; ☐ PT
- ☐ Court Report/Custody Studies
- ☐ Treatment or tests
- ☐ Allergy Records
- ☐ Consultations
- ☐ Surgical Reports
- ☐ Hospital Records
- ☐ X-Ray Reports
- ☐ Entire Record
- ☐ Other (specify)

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

- ☐ Mental Health
- ☐ HIV
- ☐ Other (specify) _____
- ☐ Developmental Disabilities
- ☐ Sexually Transmitted Disease
- ☐ Alcoholism
- ☐ Drug Abuse

For the following dates: From _____ to _____

PURPOSE FOR NEED OF DISCLOSURE: (Check all that apply)
☐ Coordination of Care ☐ Human Services investigation ☐ Obtain History ☐ Other (specify)

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 may no longer be protected by the Federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Your Rights with Respect to this Authorization:
Right to Inspect or Copy the Health Information to be Used or Disclosed – I understand that I have the right to inspect or copy 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 Privacy Officer at 715-284-4301. **Right to Receive 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 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. **Right to Withdraw this Authorization –** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: Privacy Officer at 715-284-4301. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization (s) listed above have already made in reference to this authorization. **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 redisclosure and no longer protected by Federal Privacy standards.

Disclosure Notice to Recipient of Client Health Care Records
Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, any further disclosure of patient health care records is prohibited without the specific written authorization of the person who is the subject of such records.

Expiration Date: This authorization is good until the following date(s) _____ or for one year from the date signed and covers records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed, up until the expiration date. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Consumer Signature: _____ **Date** _____

Minors parent/guardian/Legal Rep.: _____ **Relationship:** _____**Date** _____
(If the client is a minor or otherwise unable to sign the authorization, state the relationship and authority to do so)