GREEN LAKE COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Green Lake County Department of Health & Human Services
571 County Road A
Green Lake, WI 54941-0588 (920)294-4070 or (800)664-3588

I, _____, DOB: _____
(Name of Client)

authorize the Green Lake County Department of Health & Human Services **TO DISCLOSE TO/OBTAIN FROM (circle one or both):**

_____
(Name of Person and/or Organization)

_____
(Address/City/State/Zip)

The following written and verbal information (Check Applicable Categories)

___ Evaluation
___ Summary of Services
___ Discharge Summary
___ Progress Notes
___ Academic Records
___ Psychological, Psychiatric Evaluation/Diagnosis
___ Other (Specify): _____
___ Substance Abuse Assessment
___ Substance Abuse Treatment Plan
___ Substance Abuse Aftercare Plan
___ Substance Abuse Treatment Summary
___ Medical Records Including Special Tests/Medications
___ Confirmation Letter To Referral Source
___ Substance Discharge Summary
___ Drug Screen Results
___ SAP/Teacher/Counselor Involvement

For the following Dates: _____

The purpose for need of disclosure: (Check Applicable Categories)

___ Facilitate family/significant other involvement
___ Obtaining formal referral for treatment
___ Coordination of treatment
___ Establishing diagnosis and treatment plan
___ Determining and ensuring insurance coverage
___ Providing information relevant to legal proceedings
___ Provision of primary treatment
___ Providing referral source with treatment progress
___ Providing information to facilitate referral
___ Other (Specify) _____
___ Do not release any information to my primary care physician
___ Electronic transfer of information, including Internet/Faxing
___ Internet Address _____

I understand that my records are protected under the Federal and State confidentiality laws and regulations and may not be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time.

I understand that if the person(s) and/or organizations listed above are not health care providers, health plans, or health care clearing houses, 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 AUTHORIZATON:

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 confidential 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 the health information department. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under HSS 92.05 and 92.06 of the Wisconsin Administrative Code. **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 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 that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization, I may contact my GLCDHHS staff providing/coordinating my services. 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.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for one year from the date signed, up to and including treatment dates created after the date of signature. I have had opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

I further acknowledge that this information to be released was fully explained to me and this consent is given of my own free will.

SIGNATURE PATIENT/LEGAL REP: _____
DATE: _____ (If signed by other than the client, state relationship and authority in which to sign for client, i.e. deceased, minor, incompetent)

Request filed by: _____ (Employee) Date: _____ Records Released: _____

(A PHOTOCOPY OF THIS CONSENT IS AS VALID AS THE ORIGINAL)

ROUTING: White – Client File Yellow – Client