

**WASHINGTON COUNTY HUMAN SERVICES DEPARTMENT**

333 E. WASHINGTON STREET, PO BOX 2003, WEST BEND WI 53095-2003

 Suite 2100 Phone 262-335-4600 Fax 262-335-6827

 Acute Care Fax 262-365-6559

Suite 3100 Phone 262-335-4610 Fax 262-335-4709

**AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF PROTECTED HEALTH INFORMATION**

**HUMAN SERVICES DIVISION**

|  |  |
| --- | --- |
| Full Name of Client/Subject of Records (Print): |       |
| Former Name(s) if Applicable (Print): |       |  Date of Birth: |       | Phone: |       |
| Address: |       | City: |       | State: |       | Zip Code: |       |

**I hereby authorize Washington County Human Services Department to (check all that applies):**

                  Release To                   Obtain From In these Formats:                   Verbal                   Written

|  |  |  |  |
| --- | --- | --- | --- |
| Agency/Individual (Print): |       | Relationship: |       |
| Address: |       | City: |       | State: |       | Zip Code: |       |
| Phone: |       | Fax #: |       |  (Only forms will be faxed, records will be sent via U.S. Mail) |
| Print Full Name of Staff making this request: |       |

With this authorization, I understand that the Washington County Human Services Department can share written and/or verbal information regarding services I have received with the above named agency/individual. I understand that the sub-units of Washington County Human Services Department, which are subject to state and federal confidentiality laws including HIPAA may exchange information internally as needed pertaining to specific work activities.

**Dates of Requested Records/Services MUST be specified:** From:                (Month/Year) To:                (Month/Year)

**PURPOSE FOR RELEASE OF INFORMATION:**

[ ]  Attorney/Legal [ ]  Insurance Claims/Billing [ ]  Continuity of Care [ ]  Transfer of Services

[ ]  Request of individual [ ]  Chapter 51/55 Monitoring Other:

**HUMAN SERVICES DIVISION/PROGRAM**

[ ]  Adult Protective Services [ ]  Acute Care Services [ ]  Economic Support

[ ]  Behavioral Health [ ]  Family Court [ ]  Youth Justice

[ ]  Child Protective Services [ ]  Insurance Claims/Billing [ ]  Children’s Long Term Support

**SPECIFIC INFORMATION TO BE RELEASED**

[ ]  Clinical Assessment [ ]  Discharge Summary [ ]  Psychiatric Evaluation [ ]  Other (Please Indicate)

[ ]  Insurance/Funding Info [ ]  Letter/Memo [ ]  Treatment Plans

[ ]  Medication(s) [ ]  Progress Notes [ ]  Alcohol/Drug Abuse

**This authorization will expire one year from the date of signature unless otherwise specified**: \_     \_\_\_\_

I authorize the release of copies of any service records accumulated after my signature through the expiration date of this consent form.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Subject: |  | Date: |               |
| Print Name of Legal Representative: |       | Relationship to Subject of Record: |        |
| Signature of Legal Representative: |  | Date: |        |

**You must have proof of legal authority attached to this authorization before any records will be released.**

**REVOCATION OF THIS AUTHORIZATION OF RELEASING INFORMATION**

Print name of Individual revoking authorization:

Signature Revoking Authorization:                                                                                                                   Date:

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The following information is important for you to read concerning your Rights.

I understand and acknowledge the following:

 A signed copy of this authorization will be considered as valid as the original.

I have the right to Inspect and/or receive a copy of the health information to be released and I will be charged a uniform and reasonable fee for any copies of the medical records that I receive. Any fees charged will be pursuant to Washington County Code and/or the Department of Health Services fee schedule.

I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.

Revoke this authorization. I may withdraw or revoke this authorization at any time by giving written notice of my revocation to Washington County Human Services (WCHS). I understand that revocation will not be effective until received by WCHS.

That information once released under this authorization may no longer be protected by state or federal privacy standards and that the information might be re-disclosed without additional consent.

The information to be disclosed may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STD’S, HIV test results, developmental disabilities and genetic testing results.

Processing time could take up to 30 days. Records may be destroyed consistent with Federal and state laws and regulations and Washington County Code.

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| Internal Release Log – Business Use Only |  |  |  |
| Personal Health Information Released | DATE OUT | RELEASED BY | CLIENT IDENTIFICATION |
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