SAMPLE FORM

This form is meant as a sample. Each county and tribe should develop their own form and review it with partner agencies as well as appropriate legal counsel.

Coordinated Services Team Initiative
CONFIDENTIAL INTERAGENCY INFORMATION RELEASE AUTHORIZATION

Name: ________________________________ **Date of Birth:** ______________________________

Address: ________________________________ **Phone:** ______________________________

____

Complete the contact information below for each agency/individual that is authorized to release and obtain information. Cross off (X out) any boxes that are left unused/blank.

All agencies/individuals listed below are hereby authorized to release and obtain information from all of the other agencies/individuals listed below:

Agency/Individual: ____________ Address: ____________ City, State, Zip: ____________ Phone #: ____________ Fax #: ____________	Agency/Individual: ____________ Address: ____________ City, State, Zip: ____________ Phone #: ____________ Fax #: ____________
Agency/Individual: ____________ Address: ____________ City, State, Zip: ____________ Phone #: ____________ Fax #: ____________	Agency/Individual: ____________ Address: ____________ City, State, Zip: ____________ Phone #: ____________ Fax #: ____________
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Agency/Individual: ____________ Address: ____________ City, State, Zip: ____________ Phone #: ____________ Fax #: ____________	Agency/Individual: ____________ Address: ____________ City, State, Zip: ____________ Phone #: ____________ Fax #: ____________

I, ______________________________________ hereby authorize all of the named individuals/agencies listed above to release and/or obtain from any other of the above named individuals/agencies the following written and/or verbal information/records, unless otherwise specified: mental health assessment and/or treatment; psychiatric evaluation and/or treatment; psychological testing; medical and physical examinations and/or treatment; alcohol and other drug abuse assessment and/or treatment; developmental disabilities assessment and/or case management; Human/Social Service and/or Court records; educational testing, and school records, Other___________________________.

The purpose or need for the information requested is ( ) Assessment and/or Treatment; ( )Case Management Services; ( ) Interagency Coordination, Other____.

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REDISCLOSURE NOTICE: The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.

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 ***(insert your agency's name and contact information here).***

Right to Receive Copy of this Authorization – I understand that if I agree to sign this authorization, I will be provided with a copy of it.

Right to Refuse to Sign This Authorization – I understand 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. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services.)

Right to Revoke 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 the ***(insert your agency's name and contact information here).***. I am aware that my withdrawal will not be effective as to uses and/or disclosure 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 one year from the date signed.

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.

_____ **Date** _____

Signature of Child Listed on Page 1 of this Document

- Signature required for release of AODA information if 12 years old or over. Exception: outpatient or detoxification records shall be disclosed ***only*** with the consent of the minor if the minor is 12 years or older, and the minor was the only one to consent to the AODA treatment.
- The release of mental health treatment records requires the signature of ***either*** a minor over 14 ***or*** their parent or guardian.

_____ **Date** _____

Signature of Individual Authorizing Release (If signed by other than client, state relationship & authority to do so)

( ) Parent ( ) Guardian ( ) POA for HealthCare ( ) Spouse/Adult Family Member of Deceased Patient

All treatment records or spoken information which in any way identifies a client (patient) are considered confidential and privileged to the subject individual in compliance with s.51.30, Wis. Stats., DHS 92, Wis. Admin. Code, 42 CFR Part 2, and 45 CFR Parts 160 and 164. Disclosure without written client (patient) consent or statutory authority is prohibited by law.