Department of Human Services

Authorization for Disclosure of Health Information and Confidential Information

Use this form to request client records from the Eau Claire County Department of Human Services (DHS) for purposes of a client's review or for purposes of records transfer to another provider, individual, or government entity.

For questions, contact the ECC DHS Records Custodian at 715-839-6950, or by email at DHSRecordManagers@co.eau-claire.wi.us

Records are requested for the following individual(s):

First name	Last name	Date of birth

Requester information

First name	Last name

Relationship to client	Organization (if applicable)

Phone Number	Fax number	Email address

Request Information

Purpose of request:

Records requested

- ☐ Adult Protective Services (APS)
- ☐ Birth-to-Three (B-3)
- ☐ Children's Long-Term Support (CLTS)
- ☐ Child Protective Service (CPS)
- ☐ Comprehensive Community Services (CCS)
- ☐ Clinic
- ☐ Community Support Program (CSP)
- ☐ Crisis
- ☐ Jail Re-Entry
- ☐ Youth Services
- ☐ Treatment Court
- ☐ Other Records _____

Service delivery dates:

Records requested for the following dates: From_____ To_____

Records delivery

Preferred method of delivery:

- ☐ Encrypted email *
- ☐ Fax
- ☐ Mail
- ☐ Pick up

*Email delivery is only available if email address can be verified.

Please use the following fax number or email/mail address for delivery:

If records are NOT being sent directly to the client or the parents of a client under 18, this form authorizes the following individual or organization to receive client records:

Your rights with respect to this authorization

Right to Inspect or Copy the Information to be Used or Disclosed – I may arrange to inspect my behavioral health records in person by contacting the Records Custodian at 715-839-6950, or by email at DHSRecordManagers@co.eau-claire.wi.us

Right to Receive a Copy of This Authorization – I am entitled to be provided with a signed copy of this form.

Right to Withdraw This Authorization – I understand that written notification is necessary to cancel this authorization. I am aware that my withdrawal will not affect the use or disclosures of my information to the above listed party that has already been made.

Note to Disclosing Party – As a public agency, the Eau Claire County Department of Human Services is governed by the Wisconsin Open Records Law. Information the Department receives in effect becomes part of the client's record just as if it were created by the Department. A "confidential" label on a record is not sufficient to restrict client access or re-release. It can only be protected by a specific confidentiality law, Section 19.85 of the Wisconsin Statutes, or the balancing test in the Open Records Law. Therefore, please indicate any restrictions on the information you are providing.

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.

NOTE: To receive Behavioral Health records for a child aged 15 to 18, a signature is required from BOTH the child and their parent/guardian.

Signature of requester (if different from client)	Date

Signature of client or parent/guardian of client	Date

Signature of client (if ages 15 to 18 and requesting Behavioral Health Records)	Date

This release is good until one year from the date of this release.