EAU CLAIRE COUNTY DEPARTMENT OF HUMAN SERVICES
Authorization for Disclosure of Health Information and Confidential Information

Consumer Name: _____ Birth Date: _____

Street Address: _____ City, State, Zip: _____

Authorizes:
EAU CLAIRE COUNTY DEPT. OF HUMAN SERVICES
721 OXFORD AVENUE, SUITE R-1
P.O. BOX 840
EAU CLAIRE, WI 54702-0840

The following authority regarding my protected health information and other confidential information:
☐ To release to:
☐ To receive from:
☐ To verbally exchange with:
Name of Health Care Provider/Plan/Other: _____
Street Address: _____ City, State, Zip _____

Information to be released: (Check all that apply)

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

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

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

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 the Privacy Officer at 715-839-1885. **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 the Privacy Officer at 715-839-1885. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization.

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 (Wisconsin Statutes), or the balancing test in the Open Records Law. Therefore, please indicate any restrictions on the information you are providing, citing the specific law or regulation.

Expiration Date: This authorization is good until the following date(s) _____ or for 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.

Signature Consumer/Legal Rep:_____ **Date:** _____
(if signed by other than consumer, state relationship and authority to do so)

Witness _____

Print 3 copies for; ECCDHS, Recipient Agency, and Client