

Multi-Agency Release of Information Authorization

Client Name: _____ D.O.B.: _____

Address (city, state, zip): _____

Authorizes the use, exchange, and disclosure of information between the following entities:

Name of person/Organization	Name of person/Organization
Address (city, state, zip)	Address (city, state, zip)
Name of person/Organization	Name of person/Organization
Address (city, state, zip)	Address (city, state, zip)
Name of person/Organization	Name of person/Organization
Address (city, state, zip)	Address (city, state, zip)
Name of person/Organization	Name of person/Organization
Address (city, state, zip)	Address (city, state, zip)
Name of person/Organization	Name of person/Organization
Address (city, state, zip)	Address (city, state, zip)
Name of person/Organization	Name of person/Organization
Address (city, state, zip)	Address (city, state, zip)
Name of person/Organization	Name of person/Organization
Address (city, state, zip)	Address (city, state, zip)

Records/Information to be Disclosed/Exchanged (please check):

<input type="checkbox"/> Mental Health Treatment Records	<input type="checkbox"/> Educational Records	<input type="checkbox"/> Human Service Records
<input type="checkbox"/> Intake/Initial Assessment	<input type="checkbox"/> Standardized Test Scores	<input type="checkbox"/> Acknowledgement of Admission
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Teacher/Counselor/Social Worker Records	<input type="checkbox"/> Verbal/Written Communication
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Medical Evaluation/Health Records	<input type="checkbox"/> Appointment Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Other:
<input type="checkbox"/> Alcohol/Drug Treatment Records	<input type="checkbox"/> Psychological Evaluations/Test Results	

Time Period for which records are requested: From _____ to _____ All

Expiration: This authorization will remain in effect:

From the date this authorization is signed until: _____ One year from the date of signature
 Until I cancel this authorization in writing Other, specify: _____

Reason for Release (please check): Coordinating Care/Treatment Transfer of Care Case Management Personal
 Billing, collection, or payment of claims Other: _____

I understand that information will be exchanged verbally, by mail, by facsimile or by e-mail.

Redisclosure Notice to Client: If the recipient of the information is not a health care provider or health care clearinghouse, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization (s) redisclose your health information.

Disclosure Notice to Recipient of Patient Health Care Records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure Notice to Recipient of Mental Health, Alcohol and/or Drug Treatment Records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your Rights with Respect to this Authorization:

- You have the right to receive a copy of this authorization
- You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding: research-related treatment, health plan enrollment or eligibility, the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
- You understand that if you want to cancel this authorization, you must do so in writing. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- You have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form.
- Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

A photocopy of this authorization shall be as effective and valid as the original.

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 of Client (required for age 12 & over for AODA, 14 & over for Mental Health)

Date

Signature or Parent/Guardian

Relationship to Client

Date