

# WEST CENTRAL WISCONSIN BEHAVIORAL HEALTH

## CLIENT AUTHORIZATION FOR RELEASE OF INFORMATION

1. \_\_\_\_\_  
Name of Client Date of Birth Telephone Number

2. Authorizes West Central Wisconsin Behavioral Health to: Release to: \_\_\_\_\_ Obtain from: \_\_\_\_\_  
N36647 County Road QQQ  
Whitehall, WI 54773  
Provider \_\_\_\_\_

3. Information from my health care record for the following date (s): From: \_\_\_\_\_ To: \_\_\_\_\_  
\*\*Health records may be sent back to our facility via mail or fax \*\*

4. Information to be disclosed: *Identify below the specific information you are authorizing to be disclosed.*  
 Admission and Discharge Summary  Progress Notes  Surgical Reports  
 Laboratory Reports  History & Physical  X-Ray Reports  
 Dental Chart Notes  Verbal Exchange  Other \_\_\_\_\_

5. Disclosures requiring special consent: In compliance with Wisconsin Statutes, which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. *(Check all that apply)*  
 Mental/Behavioral Health Conditions  Drug/Alcohol Abuse/Treatment

6. Purpose or Need for Disclosure of Information: *(Check all that apply)*  
 Patient Request  Continuing Care  Legal  Employer Use  Insurance Use

### 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 a right to inspect or receive a copy (with a possible fee) of the health information I have authorized to be used or disclosed by this form. I may arrange to review or obtain copies of my health information by contacting WCWBH Health Information Management Department. **Right to receive a copy of this authorization** – I understand that if I agree to sign this authorization, I will be provided with a copy of it upon request. **Right to refuse to sign this authorization** – I understand that I am under no obligation to sign this form. Treatment, payment, enrollment or eligibility for benefits may not be based upon 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 that I may revoke this authorization. A description of how to revoke the authorization and any exceptions are included in WCWBH Notice of Privacy Practices. **HIV test results:** HIV test results are protected under Wisconsin state statute 252.15 and may not be disclosed without written informed consent/authorization, except to persons or organizations that have been given access by state law. A list of those persons/organizations is available upon request. **Redisclosure Notice:** I understand that any disclosure of information carries the potential for an unauthorized redisclosure, especially if the information is no longer protected by Federal or State privacy standards.

7. Expiration Date: This authorization is good until (indicate date/event) \_\_\_\_\_

8. \_\_\_\_\_  
Signature of Client if over 14 years of age Date

9. \_\_\_\_\_  
Signature of Legal Representative (State relationship to client) Date

10. \_\_\_\_\_  
Witness Date