West Central Wisconsin Behavioral Health
Client Authorization For Release of Information Form

1)_____ _____ _(___)_____
Name of Client Birthdate Telephone Number

2) Authorizes West Central Wisconsin Behavioral Health To: Release To: ___ Obtain From: ___

23062 Whitehall Rd
Independence, WI 54747

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, fax or encrypted email

4) Information To Be Disclosed: *Identify below the specific information you are authorizing to be disclosed:*

- ❑ Admission and Discharge Summary
- ❑ Laboratory Reports
- ❑ Dental Chart Notes
- ❑ Progress Notes
- ❑ History & Physical
- ❑ Other (Specify)_____
- ❑ Surgical Reports
- ❑ X-Ray Reports

5) Disclosures Requiring Special Consent: In compliance with Wisconsin Statues, 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 any that apply)

❑ Patient Request ❑ Continuing Care ❑ Legal ❑ Employer Use ❑ Insurance ❑ Other_____
Please Specify

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 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, (Exceptions: 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 statue 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