

CONFIDENTIAL INFORMATION II

RELEASE AUTHORIZATION (Rev. 5/03)

Completion of this form authorizes the release of information described in the section below called "Specific Description of Records Authorized for Release". The person (record subject) whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication / somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances. Section 51.30, Wis. Stats., DHS 92.03-92.06 Wis. Adm. Code.

Name – Person Whose Records Will be Released (Record Subject)	
Address	
City, State, Zip Code	
Identifying Number (If Any)	Date of Birth
Name - Information May be Released To WIC Staff Workers	
Organization	
Address	
City, State, Zip Code	

Name and Address – Agency / Organization Authorized to Release Information

EDS
6406 Bridge Rd
Madison WI 53704

Specific Description of Records Authorized for Release (Include dates of records, if applicable)

Information confirming whether the record subject (WIC applicant) is currently receiving Medicaid benefits.

Purpose or Need for Release of Information (Be Specific)

The Wisconsin WIC Program and the Wisconsin Medicaid Program have the same income standards for eligibility. The purpose of this release is to simplify the application process for WIC benefits by allowing the WIC Program to find out whether the record subject (WIC applicant) is currently eligible for Medicaid. If the record subject (WIC applicant) is currently eligible for Medicaid, the record subject (WIC applicant) will automatically meet the income standards for the WIC Program.

In accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

Understandings

- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:
 - No exceptions
 - Exceptions (specify): **If you decide not to sign this form, other proof of income will be needed to determine income eligibility.**
- The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.
- I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release information.
- Unless revoked, this authorization will remain in effect until the expiration time indicated below.

Choose One:

- _____ Authorization expires as of _____ (Date).
- Authorization expires **2** years from the date I sign this authorization.
- _____ Authorization expires after the following action takes place:

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

SIGNATURE - Person Whose Records Will be Released (Record Subject)		Date Signed
SIGNATURE - Other Person Legally Authorized to Consent to Disclosure	Title or Relationship to Record Subject	Date Signed