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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-02057 (08/2017) | | | | |  | | | | | | **STATE OF WISCONSIN** | | | |
| **AGING AND DISABILITY RESOURCE CENTER (ADRC)**  **AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION** | | | | | | | | | | | | | | |
| **1.** | **Individual About Whom Information is to be Disclosed** | | | | | | | | | | | | | |
| Name – Last, First, Middle Initial | | | | | | | | | | | | Phone | | |
|  | | | | | | | | | | | |  | | |
| Address – Street | | | | City | | | | | | | | State | | Zip Code |
|  | | | |  | | | | | | | |  | |  |
| Date of Birth | | | Identifying Number (if any) | | | | Email | | | | | | | |
|  | | |  | | | |  | | | | | | | |
| **2.** | **Disclosed by – Name of Agency/Organization** | | | | | | | | | | | | | |
| Name | | | | | | | | | | | | Phone | | |
|  | | | | | | | | | | | |  | | |
| Address – Street | | | | City | | | | | | | | State | | Zip Code |
|  | | | |  | | | | | | | |  | |  |
| **3.** | **Disclosed to – Name of ADRC** | | | | | | | | | | | | | |
| Name | | | | | | | | | | | | Phone | | |
|  | | | | | | | | | | | |  | | |
| Address – Street | | | | City | | | | | | | | State | | Zip Code |
|  | | | |  | | | | | | | |  | |  |
| **4.** | **Two-Way Exchange of Information**  I authorize this information to be exchanged between the designated organizations listed above.  Yes  No | | | | | | | | | | | | | |
| **5.** | **Type of Information and Records Authorized for Release** | | | | | | | | | | | | | |
| Medical records and diagnosis/prognosis  Medications  Care services received/care plan  Long Term Care Functional Screen  Bank statements or financial records  School records (including information protected under the Family Educational Rights and Privacy Act or “FERPA”) | | | | | | Benefit Specialist case file  Any and all of the above listed information that the ADRC needs to perform its duties or coordinate my services  Employment or vocational records  Other: | | | | | | | | |
| I understand that the information disclosed may include records of mental illness, alcohol/drug abuse, AIDS/AIDS related illness, and developmental disabilities unless I indicate below that I do not want such information disclosed.  Do Not Disclose:  Alcohol/Drug Abuse  AIDS/AIDS related  Mental Health/Developmental Disabilities | | | | | | | | | | | | | | |
| **6.** | **Limitations on Information to be Disclosed, if Any** | | | | | | | | | | | | | |
| Records relating to the following dates only: | | | |  | | | | to | |  | | | | |
| Records pertaining to the following conditions or events only: | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **7.** | **Effective Dates** (check one). Note if this item is left blank, the authorization will expire in one (1) year from date signed. | | | | | | | | | | | | | |
| This authorization is good until the following date or event: (mm/dd/yy) or event (specify): | | | | | | | | | | | | | | |
| **8.** | **Purpose and Use of Information Disclosed:** | | | | | | | | | | | | | |
| I authorize the above named agency/organization to disclose the above-indicated information to assist the in performing its duties and/or coordinating services for me. I understand that the ADRC may re-disclose information it receives pursuant to this authorization if necessary to establish my eligibility for programs or benefits or to coordinate my services. In addition, I understand and agree that if I move out of its service area, the ADRC can disclose information it receives pursuant to this authorization to another ADRC to coordinate the delivery of my services. | | | | | | | | | | | | | | |
| **9.** | **Signature**Please see the other side for further information and instructions. In accordance with the conditions listed above and the other side, I authorize the use and/or disclosure of my confidential information. | | | | | | | | | | | | | | |
| **SIGNATURE** | | | | | | | | | Date Signed | | | | | |
|  | | | | | | | | |  | | | | | |
| Check here if this authorization is signed by a guardian/legal representative on behalf of the individual and attach a copy of documentation to support the representation and state their relationship to the person about whom information is to be released. Relationship to Individual:  Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed:  To be signed only if individual cannot sign the authorization. | | | | | | | | | | | | | | |
| **Additional Information Regarding Disclosure of Information**  **No Obligation to Sign**: You are not required to sign this authorization. Except as permitted under applicable law, refusal to sign will not affect treatment, enrollment, or benefits eligibility. Also, you must be given a copy of the authorization form if the Authorization was requested from the ADRC.  **Right to Inspect or Copy Information to Used or Disclosed**: You have the right to inspect or have a copy (for a reasonable fee if applicable) of the confidential information you have authorized to be used or disclosed by this authorization form.  **Revocation:** You may revoke this authorization at any time by submitting a written notice of revocation to the ADRC at the address listed on the reverse side of this authorization that is providing services for you. Revocation does not apply to information that was released prior to the revocation notice.  **Re-release:** The information that you 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.  **Instructions**  **Important:** Read all instructions and information before completing and signing this form. An incomplete form will not be accepted. Follow directions carefully. If you have any questions about the release of your information, contact your ADRC.  The following are instructions for each section of the form. Type or print as clearly and completely as possible.   1. **Individual Information:** Include your full name, address, telephone number and email address (if any). 2. **Agency/Organization Authorized to Release Information:** Identify the person or organization who will be sharing your information with the ADRC (e.g., your health care provider, bank, school). Be as specific as possible. Providing location information may help make your request clearer. 3. **Type of Records Authorized for Release:** Indicate which records you would like to share with the ADRC. Use the “Other” line to provide more information if needed. 4. **Limitations on Information to be Disclosed:** Specifywhether you want to limit the authorization to information to records covering a specific time period or relating to a particular condition or event. 5. **Effective Dates:** Either check the box indicating the authorization will expire one year after signature or provide the date/event when you want the authorization to expire. 6. **Purpose and Use of Disclosed Information:** This section describesthe purpose for the disclosure of your information and how the information will be used. By signing the form, you agree to this use of your information. 7. **Sign and date this form.** If you are a legally authorized representative of the individual about whom information is to be released, sign, date, and indicate your relationship to that individual. Attach documentation showing that you are the individual’s legally authorized representative. 8. **Return signed form to the ADRC.** Please give or mail this form to the at: | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | |  | |