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| **Department of Health Services**Division of Care and Treatment ServicesF-02786 (03/2025) | **State of Wisconsin**Wisconsin Statutes§§ 146.81-84, 252.15, 938.78 and 51.30Federal Regulations42 CFR Part 2 & 45 CFR Parts 160 and 164 |
| **WRC Authorization for Use and Disclosure****of Protected Health Information (PHI)** |
| **Individual/Agency Being Authorized to Disclose Protected Health Information (PHI)** |
| Name – Individual/Agency | Phone Number | Fax Number |
|       |       |       |
| Address | City | State | ZIP Code |
|       |       |    |       |
| **Subject of Protected Health Information (Resident/Patient)** |

| Name – Resident/Patient | DOC Number | Housing Unit | Date of Birth | Phone Number |
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| Address | City | State | ZIP Code |
|       |       |    |       |
| **Recipient of Protected Health Information** |
| Name – Individual/Agency (e.g., lawyer, physician, resident/patient, family) | Phone Number | Fax Number |
|       |       |       |
| Address | City | State | ZIP Code |
|       |       |    |       |
| **Notice**: Records of Wisconsin Resource Center (WRC) that contain Protected Health Information (PHI) may include a Division of Adult Institutions and/or Division of Juvenile Corrections Health Care Record, Social Services File or Division of Community Corrections file. The records include those created by WRC and non-WRC health care providers. Disclosure of PHI can be written, electronic, or verbal. |
| **Specific Protected Health Information Authorized for Use/Disclosure** |
| **Read Carefully and Check Appropriate Boxes.** |
| [ ]  | **Two-Way Release** By checking this box, I authorize the individuals/agencies named in this authorization, to disclose to each other, the PHI identified below on an ongoing basis for the duration of this authorization. |
| [ ]  | **Check this box if a copy of an entire record may be disclosed and explain below why the entire record is needed.** Entire record includes all the types of information listed below plus correspondence, consents/refusals, medication administration sheets, flow sheets and miscellaneous documents. If this box is checked, no checkboxes in the section below need to be checked.**Explain:**       . |
| **Documents Authorized for Use/Disclosure** |
| [ ]  Problem List[ ]  Record of Immunizations and TB test Results[ ]  Medical History/Physical Exam[ ]  Progress Notes[ ]  Prescriber’s Orders/Medications [ ]  Consultations[ ]  Laboratory Results | [ ]  Medical Imaging Reports (x-rays, MRIs, etc.)[ ]  Psychiatric (may include AODA/SUD diagnoses)[ ]  Psychological (may include AODA/SUD diagnoses)[ ]  AODA/SUD Program/Treatment Information[ ]  Optical[ ]  Dental[ ]  Patient Request Folder/OnBase (e.g., Health Service Requests, Medication/Medical Supply Refill Requests) |
| **This authorization may include medical, mental health, developmental disability, and alcohol/drug abuse/substance use disorder information, and HIV test results, unless excluded below.** |
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| **Describe time period of records by entering start and end dates**.If no dates are entered, records for the most recent 12 months will be provided. |
| From:       | To:       |
| If Authorization is limited to or includes specific youth/juvenile medical or mental health conditions(s), describe (include time period): |
|       |
| Use F-24319A for WRC resident location information. |
| **Purpose or Need for Disclosure of Protected Health Information (check applicable category)** |
| [ ]  Ongoing health care/treatment | [ ]  Review by patient  | [ ]  Legal representation/proceedings (Court/Administrative) |
| [ ]  Coordination of care of eligibility for services/benefits | [ ]  Review by family member/friend |
| [ ]  Other:       |
| **Resident/Patient Rights** |
| **Right to Receive Copy of This Authorization**. Residents/patients have a right to receive a copy of this form after signing it.**Right to Refuse to Sign This Authorization**. WRC cannot condition treatment or payment for treatment based on a resident/patient’s decision not to sign this form, except for research-related treatment and provision of health care solely for the purpose of creating PHI for disclosure to a third party.**Right to Withdraw This Authorization.** Residents/patients have the right to revoke this Authorization at any time by completing a Revocation of Authorization for Use/Disclosure of PHI F-02787 or equivalent. Revocation is effective when WRC or other individual/agency authorized to disclose PHI, receives the form and is not effective regarding the uses/disclosures of PHI made prior to receipt of the F-02787, or equivalent. **Re-Disclosure**. If a resident/patient authorizes disclosure to an individual/agency not covered by laws that prohibit re-disclosure, the PHI may be re-disclosed by that individual/agency. If Substance Use Disorder (SUD/AODA) records have been disclosed:The record that has been disclosed is protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit one from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR Part 2. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except provided under §§ 2.12(c)(5) and 2.65.**Right to Inspect and/or Copy PHI**. Residents/patients have the right to inspect, and obtain copies of PHI for a reasonable fee used/disclosed based upon this form. Except for medication/somatic treatment records, a director/designee of ta treatment facility for mental illness, developmental disability, and alcohol or drug abuse may deny that right during treatment in some circumstances. Wis. Stats. §51.30 Wis. Admin. Code §§ DHS 92.03-92.06.**Authority to Sign F-02786**. An adult is a person 18 years or older.* Adults can sign the form regarding all types of PHI about themselves.
* A court appointed guardian of the person or an agent under an activated Power of Attorney for Health Care (POAHC) can sign the form for the incompetent adult or principal regarding all types of PHI, unless restricted by the Letters of Guardianship or POAHC document.
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| **Authorization Expiration: Date/Event** |
| This Authorization is in effect until the following date or event: |       . |
| If no date/event is entered, this Authorization expires one year from the date of signing. |
| I have read or had read to me this Authorization form. I have had an opportunity to ask questions. By signing this Authorization, I am confirming that it accurately reflects my wishes regarding use and disclosure of my Protected Health Information. I understand that there may be a charge for copies. |
| **Signature** – Resident/Patient | Date Signed |
|  |  |
| **Signature** – Other Person Legally Authorized toConsent to Disclosure (If Applicable): | Relationship to Resident/Patient[ ]  Legal Guardian [ ]  Parent of Minor[ ]  Next of Kin [ ]  Health Care Agent[ ]  Personal Representative[ ]  Other:       | Date Signed |