

**AUTHORIZATION TO DISCLOSE INFORMATION TO THE WISCONSIN
DEPARTMENT OF HEALTH SERVICES KATIE BECKETT MEDICAID**

INSTRUCTIONS: Read the entire form and the Authorization to Disclose Information to the Wisconsin Department of Health Services Katie Beckett Medicaid Instructions, F-03096A, before completing this form and signing below. This form lets you voluntarily allow and ask to disclose all your medical and education records and other information related to your ability to perform tasks. This authorization is valid for 12 months from the date you sign below and includes permissions to release:

- All records from this facility (including copies of medical records from other facilities if they are included in your chart) regarding your treatment, hospitalization, and outpatient care for conditions listed below:
 - Psychological, psychiatric, or other mental impairment(s) (excludes psychotherapy notes as defined in 45 C.F.R. 164.501)
 - Substance use disorder, including alcoholism
 - Gene-related impairments, such as sickle cell anemia (including information from genetic test results or screenings)
 - Sexually transmitted infections, including HIV
- Information about how your impairments affect your ability to work and complete daily living activities
- Copies of educational tests or evaluations, including individualized educational programs, psychological or speech evaluations, teachers' observations, and any other records that can help evaluate function
- Information created within 12 months after the date of this authorization, as well as past information

This information will be collected from:

- All medical places of service, including hospitals, clinics, and labs.
- Social workers.
- Educational sources.
- Bureau of Clinical Policy and Pharmacy (BCPP) consultative examiners.
- Family members and others that may have information about your condition.

This information will be released to and used by the Wisconsin Department of Health Services (DHS) in order to process your case and determine your eligibility for Katie Beckett Medicaid. By signing this form, you acknowledge:

- Your signature will authorize the use of a copy of this form for the disclosure of information described above.
- Under some circumstances, this information may be disclosed to other parties.
- Your signature will authorize the Disability Determination Bureau (DDB) to exchange the information described above with the BCPP and Bureau of Children's Services (BCS).
- You may write to DHS and other sources to revoke this authorization at any time.
- Upon your request, DHS will give you a copy of this form.
- You have the right to review or request copies of the released material, and the confidentiality of your records is protected by law.
- You have read the entire form and agree to the disclosures above from the sources listed.

RECORDS DISCLOSURE APPLICANT INFORMATION

Name – Applicant (First, Middle, Last)

Social Security Number

Date of Birth

Have you applied for Social Security Insurance (SSI) benefits in the last three months, or do you intend to apply for SSI benefits within the next three months?

Yes

No

SIGNATURE – Individual Authorizing Disclosure

Date Signed

Print Name – Individual Authorizing Disclosure

If the person who signed the form is not the applicant, specify their relationship to the applicant:

- Parent of minor
- Power of attorney for health care (Provide copy of Power of Attorney for Health Care papers.)
- Legal guardian (Provide papers showing court appointment.)
- Other (Explain) _____

SIGNATURE – Child / Applicant (If age 12 or older, you must sign.)

Print Name – Child / Applicant (If age 12 or older, you must sign.)

OFFICE USE ONLY – Complete if a voice signature is documented by the worker.

Name – Individual (First, Middle, Last)

Worker ID

Phone Number – Worker

Address (Street, City, State, Zip Code) – Worker
