DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-03096B (05/2023)

STATE OF WISCONSIN

AUTHORIZATION TO DISCLOSE INFORMATION TO THE WISCONSIN DEPARTMENT OF HEALTH SERVICES KATIE BECKETT MEDICAID: CLINIC-SPECIFIC

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

All of the above records may be released **except**: _____

This information will be collected from the following clinic.

Clinic Name

Clinic Address (Street, City, State, Zip Code)

Clinic Phone Number	Clinic Fax Number

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 Bureau of Clinical Policy and Pharmacy (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

Reset Form