CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION F (5/20)

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 & Address – **Agency/Organization I Authorize to Release Information**

Name - **Information May be Released To**

Organization

Address

City, State, Zip Code

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

Purpose or Need for Release of Information (Be Specific)

Understandings

- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:
  ☐ No exceptions ☐ Exceptions (specify):
- 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.

☐ Check here if you consent to disclosing your records, including substance use disorder treatment information to health care providers and entities which have a current or future treating provider relationship with you and to the Wisconsin Statewide Health Information Network, Inc. ("WISHIN") for disclosure to WISHIN's participants. Your consent includes all your substance use disorder records, such as those relating to: Diagnosis, treatment and referral for treatment, billing information, emails, voicemails, texts; medications, dosages, lab results, allergies, diagnostic information and substance use history and summaries.
The purpose of this consent is that your records, including substance use disorder records will be shared with your current and future health care providers who participate in the WISHIN which have a treating provider relationship with you to help diagnose, treatment and manage your health care. Upon written request, we will provide you with a list of entities to which your information has been disclosed in the WISHIN.

- 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, unless I do not complete, I understand this consent will end upon my death.

Choose One:

☐ Authorization expires as of (Date).

☐ Authorization expires month(s) 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