

## CONFIDENTIAL INFORMATION STATE OPIOID RESPONSE GPRA RELEASE (07/2023)

Completion of this form authorizes the release of information described in the section below called "Specific Description of Information for Release".

	Name	
	Address	
	City, State, Zip Code	
	Identifying Number (If Any)	Date of Birth
Name & Address – <b>Agency/Organization I Authorize to Release Information</b>	<b>Information May be Released To</b>	
	Organization University of Wisconsin-Population Health Institute	
	Address 610 Walnut Street	
	City, State, Zip Code Madison, WI 53726	
<b>Specific Description of Information for Release</b>  Government Performance and Results Modernization Act of 2010 (GPRA) data collected through this program.	<b>Information May be Released To</b>	
	Division of Care and Treatment Services	
	Organization Wisconsin Department of Health Services	
	Address 1 W. Wilson St. City, State, Zip Code Madison, WI 53703	
<b>Purpose or Need for Release of Information</b> This information is being collected as part of the State Opioid Response Grants implemented by the Wisconsin Department of Health Services (DHS) with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). The UW Population Health Institute is a partner with DHS on this project. The information collected through this program will provide key insight into the impact and progress of the program, and allow for an overall evaluation of these programmatic efforts. This program will operate from <b>9/30/2022 to 9/29/2024</b> or until the project ends. Providers offering services through this program will provide evidence-based treatment and services. Services may include a range of substance use related services such as, but not limited to, outpatient and residential-treatment, use of peer recovery support specialists, medication assisted treatment and naloxone, and other recovery support services. <b>For Verbal Consent:</b> Explain the study to the potential subject verbally according to GPRA training protocol, providing all pertinent information (purpose, procedures, risks, benefits, alternatives to participation, etc.), and allow the potential participant ample opportunity to ask questions or voice concerns.		
<b>Understandings</b> <ul style="list-style-type: none"><li>This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:<ul style="list-style-type: none"><li><input checked="" type="checkbox"/> No exceptions</li><li><input type="checkbox"/> Exceptions (specify):</li></ul></li><li>The information that I authorize to be released may be redisclosed by the recipient only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.</li><li>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.</li><li>Unless revoked, this authorization will remain in effect until the expiration time indicated above.</li></ul>		
<b>Choose One:</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Authorization expires as of _____ (Date).</li><li><input type="checkbox"/> Authorization expires _____ month(s) from the date I sign this authorization.</li><li><input checked="" type="checkbox"/> Authorization expires after the following action takes place: Upon conclusion of this project.</li></ul>		
<b>As evidenced by my signature, I hereby authorize disclosure of Information to the person(s) or agency(s) specified above.</b> <input type="checkbox"/> Verbal consent was received by participant. Name of person receiving verbal consent: _____ Signature of person receiving verbal consent _____ Date consent received _____		
<b>SIGNATURE</b> - Person Whose information Will be Released		Date Signed
<b>SIGNATURE</b> - Other Person Legally Authorized to Consent to Disclosure	Title or Relationship	Date Signed