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Governor

Helene Nelson
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**Restriction of Patient Health Information
Regarding Medicaid Autism Services**

To assist transitioning to the waiver alternative, we will forward your child's name, your name, and address to your county agency. If you do not want this information to be forwarded, please complete and send this form to the address listed below by July 15, 2003. By sending this form, you are stating that you *DO NOT* wish to have your child receive continued in-home autism services that will be provided under the waiver alternative beginning in the fall.

I hereby do not authorize disclosure of the named individual's health information to my county human services agency.

Patient First Middle Last

Date of Birth

Medicaid Card Number

Home Phone Number

Signature of Parent or Legal Guardian

Date

Mail this form by July 15, 2003, to:

Alan White
Bureau of Program Integrity
P. O. Box 309
1 W. Wilson Street
Madison, WI 53701-0309

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