JUNEAU COUNTY
AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH AND OTHER CONFIDENTIAL INFORMATION

_____ _____ / _____ / _____ _____
Name Date of Birth Phone Number

_____
Address City State ZIP Code

AUTHORIZES: Juneau County, Mauston, WI 53948 Department: Human Services

(Check all applicable) TO EXCHANGE: ☐ **RELEASE TO:** ☐ **RECEIVE FROM:** ☐

_____
Individual/Agency/Organization Phone Number

_____
Address City State ZIP Code

INFORMATION TO BE USED AND/OR DISCLOSED: The following information to be released may be Written, Verbal, Voicemail, Fax, or Electronic. (Check all applicable categories)

☐Initial Assessment ☐Mental Health Records ☐Early Intervention Records
☐Medications ☐Psychological Evaluation ☐Family and Safety Assessments
☐Progress Notes ☐Medical Records ☐Financial Information
☐AODA Record ☐Case Plans/Evaluations
☐Other (specify): _____

Records to be disclosed between the dates of _____ and _____

NEED OR PURPOSE OF DISCLOSURE: (Check all applicable categories)

☐Continuity of Care ☐Further Medical Care ☐Insurance Eligibility/Benefits
☐Educational Planning ☐Personal ☐Changing Providers
☐Coordination of Services ☐Evaluate and Plan an Individualized Program
☐Other (specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that Juneau County may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, and b) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. **Right to Withdraw This Authorization -** I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal. I am aware that my withdrawal will not be effective until received by Juneau County and will not be effective regarding the uses and/or disclosures of my health information that Juneau County has made prior to receipt of my withdrawal statement. **Right to Inspect or Copy the Health Information to Be Used or Disclosed -** I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Juneau County.

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL.

RE-DISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is valid until _____(date). If no expiration date is indicated, this authorization shall expire one year from date signed below. By signing this authorization, I am confirming that it accurately reflects my wishes. This authorization shall also extend to records of future treatment after the date of signature, as long as such treatment occurs while this authorization is still in effect.

SIGNATURE: _____ DATE: _____

If this authorization is signed by a legal representative* on behalf of the individual, complete the following:

Legal Representative's Name: _____

*Relationship to Client: _____
(Must state relationship to client and have available proof of legal authority upon request.)