HO-CHUNK NATION DEPARTMENT OF HEALTH

Client Name | Client Phone | Client DOB

Information to be released TO / RECIPROCALLY (circle one)	Information to be released FROM / RECIPROCALLY (circle one)
Agency/Person	Agency/Person
Address	Address
Phone Fax	Phone Fax

Prohibition on Disclosure of Information*: This release accompanies a disclosure of information that may concern a client in alcohol/drug abuse treatment from records protected by Federal confidentiality rules 42 C.F.R, Part 2. The Federal rules prohibit you from making any further redisclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R, Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal regulations restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse client.*

I authorize the following information to be released, for records dating from _____ to _____:

☐ Mental Health ☐ AODA ☐ Medical Records ☐ Dental Record ☐ Other: _____

I authorize this information to be released: ☐ verbally ☐ written

I authorize this information to be released for ***1 year***, or until: _____-_____-_____

The purpose of this disclosure: ☐ continuity of care ☐ legal

(be as specific as possible) ☐ other: _____

Records being requested: _____

I understand that my records (including my alcohol, drug abuse, or mental status information) are protected under the Federal Confidentiality Regulation and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this consent expires automatically as described below. I understand that I have the right to inspect and receive a copy of my mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code. I understand that HHCC Department of Health will not condition treatment or eligibility for direct care on my providing this authorization. This Authorization for the Release of Confidential Information shall become effective on the date of execution of my signature hereinafter, and this Authorization, which grants specific authority for the release of protected health information by the Ho-Chunk Nation Department of Health. I retain the rights to revoke this Authorization at any time by providing a written notice to the Ho-Chunk Nation Department of Health, but I understand and agree that my consent to release information shall remain in effect until the date the revocation is noted on this form, and any documents released previous to that date are considered to be authorized and approved by me.

Signature of Client or Parent, Guardian, Conservator, or Authorized Representative **Date**

_____

DO NOT COMPLETE THIS SECTION UNLESS YOU ARE REVOKING YOUR RELEASE OF INFORMATION.

I, _____, hereby revoke this authorization for releases of information

Signature of Client or Parent, Guardian, Conservator, or Authorized Representative **Date**

_____

45 C.F.R 160 & 164; 42 C.F.R, Part 2; Sec. 51.30,; Wis. Stats,; DHS 92.03-92.06 Wis. Adm. Code