HO-CHUNK NATION DEPARTMENT OF HEALTH

Client Name **Telephone Number** **DOB**

Information to Be Released From/To

Agency/Job Title or Individual Name **Address** **City/State/Zip**

Phone Number **Ext.** **Fax Number**

Information to Be Released To/From

Agency/Job Title or Individual Name **Address** **City/State/Zip**

Phone Number **Ext.** **Fax Number**

Prohibition on disclosure. *This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42CFR, Part 2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. The Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of this law shall be fined in the case of each subsequent offense.*

I authorize the following information to be released: **For the time period from** _____ to _____.

___Mental Health ___AODA ___Medical Record ___Dental Record ___Other: _____

Form in which information may be released: ___Verbal ___Written

_____ If initialed here, communication is allowed until: _____ If not, communication is allowed for 1 year, or until revoked by me.

The purpose of this disclosure: _____

(As specific as possible)

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, Parent, Guardian, Conservator or Authorized Representative

Date

Witness Signature

Date

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.

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

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

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

Witness Signature Date