1. Client Name: ___________________________
Maiden/Former Name: ______________________
Date of Birth: ______________________________
Address: _________________________________
____
Phone Number: ____________________________

Unified Community Services

Serving Grant and Iowa Counties

200 W. Alona Lane
Lancaster, WI 53813
Phone: (608) 723-6357
Fax: (608) 723-4417

1122 Professional Drive
Dodgeville, WI 53533
Phone: (608) 935-2776
Fax: (608) 935-3174

2. I hereby Authorize:

Unified Community Services (UCS)

☐To exchange information with ☐To disclose information to ☐To receive information from

____ ____
Name of Organization and/or Person Phone Number

____ ____
Street Address City State Zip

3. **Please check only one:**

☐ No records needed at this time. File in client's record for future use.

☐ Mail Records

☐ Will Pick Up Records (check only one box): ☐ UCS Lancaster ☐ UCS Dodgeville

☐ Fax Records to fax number: ________________

☐ Other: ____

4. **Format for Records (check only one):** ☐ Paper ☐ CD/DVD (requires PDF viewer)

☐ Other:____

5. State and Federal Laws require a specific authorization prior to disclosing certain information, and the type(s) of information to be disclosed.

- 2 year history unless specified: __/__/__ to __/__/__

☐ Mental Health

☐ Assessment ☐ Treatment Plan ☐ Discharge Summary ☐ Progress Notes ☐ Medications ☐ Crisis
☐ Other: ____

☐ Substance Abuse

☐ Assessment ☐ Treatment Plan ☐ Discharge Summary ☐ Progress Notes ☐ Medications ☐ Crisis
☐ Other: ____

☐ Developmental Disability

☐ ASQ ☐ Individual Service Plan ☐ Functional Screen ☐ Therapist evaluations & notes
☐ Prescription and Plan of Care ☐ Other:____

☐ Medical

☐ Medications ☐ Lab Reports* ☐ Discharge Summary ☐ Assessment ☐ Progress Notes*
☐ Other: ____
* Releasing drug testing results may have negative legal, employment, child custody, & other consequences

6. Purpose or need for disclosure: ☐ Request of client ☐ Insurance application/claim

☐ Further medical care/continuity of care/coordination of services ☐ Legal Investigation

☐ Disability Determination ☐ Other ____

7. Expiration Date: This authorization is valid for 15 months from date of signature or until ______________ (specific date up to 2 years) and covers records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed, up until the expiration date.

Client Name: ________________________ Date of Birth: ______________________

Your Rights With Respect To this Authorization

General Statement of Rights: Federal and state laws protect the confidentiality of my Protected Health Information (PHI) including but not limited to: Mental Health – Sec 51.30, Wis. Stats; & DHS 92, Wis. Admin. Code. Alcohol & Other Drug Abuse – Sec. 51.30 Wis. Stats, DHS 92, Wis. Admin. Code; and 42 CFR Part 2 Final Rule governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties.

Prohibitions on Redisclosure: This information has been disclosed to you from records protected by Wisconsin Administrative Code DHS 92.03 and/or Federal confidentiality rules (42 CFR part 2).

- DHS 92.03 requires that no personally identifiable information in treatment records may be re-released by a recipient of the treatment record unless re-release is specifically authorized by informed consent of the subject individual, DHS 92.03 or as otherwise required by law.
- The Federal rules prohibit you from making any further re-disclosure 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 CFR Part 2. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164.

Right to Receive a Copy of this Authorization: I have a right to receive a copy of this form after I sign it.

Right to Refuse to Sign This Authorization: I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Right to Withdraw This Authorization: I have the right to withdraw this authorization at any time by providing a written* statement of withdrawal to the individual/agency authorized to disclose PHI. My withdrawal of consent will not be effective until the individual/agency authorized to disclose PHI receives it, and will not be effective regarding the uses and/or disclosures of my PHI made prior to receipt of my withdrawal statement. *Consent for substance abuse treatment may be revoked verbally.

Re-disclosure: If I authorize release of PHI to an individual or agency not covered by federal or state laws that prohibit re-disclosure, my PHI may not remain confidential.

Right to Inspect and/or Copy PHI: I have the right to inspect and receive copies of my PHI as permitted by law. I may be charged a reasonable fee for these copies.

In accordance with the conditions listed on the first page of this form and above, I authorize the use and disclosure of my protected health information. This form must be legible and the first page must be completed in full (numbers 1– 7) in order to be valid.

Signature of Client: ____ **Date:**____________________

Signature of Parent/Guardian: ____________________________________ **Date:**_____ ______________

Mental Health: For a minor who receives **mental health** treatment, parent/guardian must sign if under 14; for a minor 14 and over either the minor or the parent may sign.

Substance Abuse: For a minor who receives **substance abuse** treatment, minor and parent/guardian must sign, except if a minor 12 and older receives substance abuse treatment without parental consent, the minor alone may sign.

Developmental Disability: A **developmentally disabled** minor 14 and over shall be notified of the right to file a written objection to access to treatment records by parent/guardian.

Guardian must sign for any adult with a legal guardian.

Legal Authority: If not signed by client, identify relationship to client. If other than a parent of minor, obtain court order or other documentation establishing the person's authority

☐Parent of Minor ☐Legal Guardian ☐Spouse of Deceased ☐Personal Representative/Domestic Partner of Deceased
☐Health Care Agent ______________________________ ☐Other: ______________________________________