Fond du Lac County Department of Human Services
INFORMED CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Fond du Lac County Department of Human Services Locations:

Health Care Center (HCC) - 459 E. First St.
Clinical Services Division (920) 929-3500
Mental Health; SUD; CCS; Crisis; Inpatient Services

FDL County Campus (FCC) - 400 University Dr. Ste A1
Community Services Division (920) 929-3500
Birth to 3; CLTS/CCS; CST; CCOP

Child Welfare Division (920) 929-3500
Access; Ongoing; Youth; Placement; Group Homes

Aging and Disability Resource Division
ADRC; Aging **(920) 929-3466**

1. Regarding Client:

Last Name First Name MI

Street Address

City State Zip

Date of Birth Previous/Maiden Name Phone

2. Release From: ☐ **Exchange With**

Name

Street Address

City State Zip

Attention: _____ Phone/Fax: _____

3. Release To:

Name

Street Address

City State Zip

Attention: _____ Phone/Fax: _____

4. Specific type of information to be disclosed:

☐ Access Reports
☐ Appointments/Attendance
☐ Child and Family Records
☐ Discharge Summary
☐ Mental Health Records
☐ Financial Information
☐ Intake/Initial Assessment
☐ Juvenile Records
☐ Lab Reports
☐ Substance Use Disorder (SUD) Records
☐ Medical Evaluations/H&P
☐ Medications
☐ Psychiatric Evaluation
☐ Psychological Evaluation
☐ Psychosocial Evaluation
☐ Social History
☐ Staffing/Progress Notes
☐ Treatment/Service Plan/Reviews
☐ OTHER:

_____

In the form of: ☐ Photocopies ☐ Verbal Communication ☐ Inspection ☐ OTHER:_____

5. Which may include information regarding the treatment of emotional/mental illness, HIV/AIDS, substance use disorders, developmental disabilities, sexually transmitted diseases, for the following dates: _____

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Upon request I may be provided a list of entities to which my information has been disclosed.

☐ **May include future records regarding my treatment until the date or condition of expiration**

6. Purpose or need for disclosure:

☐ Continuing Care
☐ Case Management
☐ Insurance/Eligibility/Benefits
☐ Legal Purposes
☐ Personal
☐ Other:_____

7. This consent will remain in effect until:

☐ Above request is processed ☐ Billing procedure is complete
☐ Additional time period this authorization is valid:
One Year From Signature Date (one year maximum)

CLIENT RIGHTS (PLEASE READ BEFORE SIGNING): *You may request multiple releases of information identified on this authorization form, however, releases based on this form are limited to records dated up to and including the date of your signature. A new authorization is needed for the release of information for care provided after the date of signature, unless you have indicated "disclosure may include future records," or unless the release is otherwise permitted by law. You may receive a copy of this authorization. Copies of records will be provided in accordance with facility procedure at a reasonable copy fee. You have the right to inspect and receive a copy of the material to be disclosed in accordance with Department Policies. You may revoke this authorization at any time, (except to the extent that the organization has already acted in reliance upon it), by written notification to the disclosing medical records/health information department. Refusing to sign this document will not withhold services. Please review the Notice of Privacy Practices for a more complete description of disclosures prior to signing this consent. I understand that any information disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. Any information released will be kept to the minimum necessary as noted in the Specific Type of Information to be released. I hereby release the Fond du Lac County Department of Human Services from all legal responsibilities or liability that may arise from this act of disclosure. A photocopy of this authorization/consent shall be as valid as the original.*

CLIENT SIGNATURE: _____ **DATE:** _____

AUTHORIZED PERSON: _____ **RELATIONSHIP:** _____
(Parent/Guardian/Legal Representative)

WITNESS: _____