AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Recipient of Service ______________________ Street or Box Number ______________________

Date of Birth ______________________ City, State, Zip Code ______________________

I authorize Oneida County Department of Social Services, P.O. Box 400, Rhinelander, WI 54501
(Name of Organization or Individual) (Address)

to disclose to ______________________
(Name of Organization or Individual) (Address)

and authorize ______________________
(Name of Organization or Individual) (Address)

to disclose to Oneida County Department of Social Services, P.O. Box 400, Rhinelander, WI 54501
(Name of Organization or Individual) (Address)

information from my confidential record. I understand that the specific type of information to be disclosed includes: ______________________

and that this disclosure is being made for the following purpose(s): ______________________
This authorization for disclosure of information is effective until: ______________________

(Specify date, event, or condition upon which consent will expire, unless revoked earlier. The release shall not extend more than one year from the date signed.)

I understand that I will receive a copy of this authorization and that I have the right to inspect and receive a copy of the material to be disclosed upon my request. 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.

(Signature of Recipient of Service if over age 12) ______________________ (Date) ______________________

(Signature of Parent, Guardian, or Witness, if necessary) ______________________ (Date) ______________________

(Relationship to Recipient of Service Above) ______________________ (Parent, Guardian, Self) ______________________

The following statements are applicable only to protected health and drug and alcohol abuse information and services.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Oneida County DSS may not condition treatment, payment, enrollment or eligibility for benefits on my decision to sign this authorization except regarding: a) health plan enrollment or eligibility.

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 to Oneida County DSS. I am aware that my withdrawal will not be effective until received by Oneida County and will not be effective regarding the uses and/or disclosures of my health information that Oneida County has made prior to receipt of my withdrawal statement.

NOTE TO RECIPIENT OF MEDICAL RECORD INFORMATION: This confidential information is not to be released to other sources without again seeking the permission of the client.

NOTE TO RECIPIENT OF DRUG AND ALCOHOL ABUSE INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Unless the records of your program are also subject to the Federal Law, Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

PHOTOCOPY VALID AS ORIGINAL