



# ONEIDA COUNTY HUMAN SERVICES

*Better Together*

## AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

**[Individual/Patient/Client/Insured]:**

Name of Individual/Previous Names Birth Date

Street Address City, State, Zip Phone

**I authorize:** Oneida County Human Services - 1 S. Oneida Ave / 705 E. Timber Dr. / 100 W. Keenan St, Rhinelander, WI 54501

**to disclose to:** \_\_\_\_\_

**and authorize:** \_\_\_\_\_

**to disclose to:** Oneida County Human Services - 1 S. Oneida Ave / 705 E. Timber Dr. / 100 W. Keenan St, Rhinelander, WI 54501

### INFORMATION TO BE USED OR DISCLOSED:

The following is a specific description of the health information I authorize to be used and/or disclosed Including:

[Check all that apply]

Date Range: \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AODA Records / Assessment/Results                            | <input type="checkbox"/> Family Interaction Plan/Visits    | <input type="checkbox"/> Psychiatric/Psychological Evaluation & Reports   |
| <input type="checkbox"/> Appointments/Scheduling                                      | <input type="checkbox"/> HIV Test Results                  | <input type="checkbox"/> Provider/Facility Name(s)  |
| <input type="checkbox"/> Attendance Records   | <input type="checkbox"/> Intake/Initial Assessment         | <input type="checkbox"/> Recommendations & Referral   |
| <input type="checkbox"/> Case Notes/Records   | <input type="checkbox"/> Medicare Wellness                 | <input type="checkbox"/> School Information: Report Cards, Electronic Student Record, IEP, Face-face with child at school |
| <input type="checkbox"/> Court Progress   | <input type="checkbox"/> Medications/Medication Records    | <input type="checkbox"/> Social History   |
| <input type="checkbox"/> Diagnoses medical, mental health, developmental disabilities | <input type="checkbox"/> Mental Health                     | <input type="checkbox"/> Testing Results  |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Observations                      | <input type="checkbox"/> Treatment Plans/Reviews  |
| <input type="checkbox"/> Drug/Hair Test Results                                       | <input type="checkbox"/> PCP Eval/Notes                    | <input type="checkbox"/> Verbal, written, & electronic communication  |
|   | <input type="checkbox"/> Placement Information             |   |
|   | <input type="checkbox"/> Progress/Staffing Notes & Reports |   |

Other (specify) \_\_\_\_\_

### PURPOSE OF DISCLOSURE: [Check all that apply]

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> At the request of the individual       | <input type="checkbox"/> Claims Resolution     | <input type="checkbox"/> Continuity/Coordination of Services/case management       |
| <input type="checkbox"/> Coordinating Care for Dependent/Spouse | <input type="checkbox"/> Further Medical Care  | <input type="checkbox"/> Insurance Eligibility/Benefits                            |
| <input type="checkbox"/> Investigations/Action Proceedings      | <input type="checkbox"/> Mental Health Records | <input type="checkbox"/> Monitoring Compliance w/Tx Plan or w/Driver's Safety Plan |
| <input type="checkbox"/> Other (specify) _____                  |  |  |

Human Services - Court House  
1 S. Oneida Ave  
Rhinelander, WI 54501  
P: 715-362-5695 F: 715-362-7910

Human Services – Timber Drive  
705 E. Timber Drive  
Rhinelander, WI 54501  
P: 715-369-2215 F: 715-369-2214

Aging & Disability Resource Center  
100 W. Keenan St  
Rhinelander, WI 54501  
P: 715-369-6170 F: 715-369-6245

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**Right to Receive Copy of This Authorization** - I understand that if I sign this authorization, I will be provided with a copy of this authorization upon my request.

**Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be conditioned on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. **Note, WI law requires the client/patient's authorization to disclose 252.15 records for payment purposes.**

**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 Human Services and the other party to this form. I am aware that my withdrawal will not be effective until received by both Oneida County Human Services and the other party to this form and will not be effective regarding the uses and/or disclosures of my health information that were made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

**Right to Inspect or Copy the Health Information to Be Used or Disclosed** - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Oneida County Human Services or the other party to this form.

**REDISCLOSURE NOTICE:** 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. However, Wisconsin law requires any disclosure or re-release, except oral disclosure, of confidential information from treatment records, be accompanied by a written statement which states that the information is confidential and disclosure without client/patient consent or statutory authorization is prohibited by law.

**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.

**EXPIRATION DATE:** This authorization is valid for only the specific dates listed below. If no expiration date is indicated, this Authorization shall expire one year from the date signed. By signing this authorization, I am confirming that it accurately reflects my wishes.

Valid from: \_\_\_\_\_ to: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE CLIENT/PATIENT (Required age 14 and older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
SIGNATURE PARENT/LEGAL REP

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Recipient