ONEIDA COUNTY

DEPARTMENT OF SOCIAL SERVICES

Professional Services ~ Positive Outcomes

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:

☐ **AODA Assessment/Results**	☐ **Electronic Student Record**	☐ **Psychiatric/Psychological Evaluation & Reports**
☐ **Appointments/Scheduling**	☐ **Family Interaction Plan/Visits**	☐ **Recommendations & Referral**
☐ **Attendance**	☐ **IEP**	☐ **Report Card**
☐ **Case Notes/Records**	☐ **Medications**	☐ **School Information (Including Face-face with child at school)**
☐ **Court Progress**	☐ **Mental Health**	☐ **Testing Results**
☐ **Diagnoses**	☐ **Observations**	☐ **Verbal, written, & electronic communication**
☐ **Discharge Summary**	☐ **Placement Information**	☐ **Other (list)** ________________________
☐ **Drug/Hair Test Results**	☐ **Progress Notes/Reports**	☐ **Other (list)** ________________________

and that this disclosure is being made for the following purpose(s): Case Management, Investigation, Court Services & Treatment Planning

This authorization for disclosure of information is effective until: One year from date of signing
(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)

Telephone: 715-362-5695	1. S. Oneida Avenue	IM Central Consortium
Toll Free: 1-888-662-5695	P.O. Box 400	(Badger Care/Food Share)
Fax: 715-362-7910	Rhinelander, WI 54501	1-888-445-1621

oneidadss@dss.co.oneida.wi.us

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.