Aging & Disability Resource Center

Serving Adams, Green Lake, Marquette and Waushara Counties

Consent for Release of Confidential Information

I, _____, DOB: _____

Authorize the ADRC serving Adams, Green Lake, Marquette, and Waushara Counties to DISCLOSE TO/OBTAIN FROM (Circle one or both):_____

_____

_____

_____

_____

The following information, whether in written, verbal or electronic form (check applicable categories):

_____ Medical History and Physical
_____ Diagnosis
_____ IQ Testing
_____ School/Educational Records
_____ Prescriptions
_____ Laboratory Reports and Results
_____ Hospital and Medical Records (including all reports, special tests and medications)
_____ Law Enforcement/DOC Records
_____ Progress Notes
_____ AODA records
_____ HIV Test Results
_____ AIDS or AIDS-related Illnesses
_____ Itemized statements of all charges for medical treatment
_____ Discharge Summary
_____ Mental Health records
_____ Employment records
_____ Other _____

The purpose of the need for disclosure:

_____ Facilitate family/significant other involvement
_____ Complete Long Term Functional Screen
_____ Provide Information to facilitate referral
_____ Transfer Long Term Care Functional Screen
_____ Access Program Eligibility
_____ Coordination of services
_____ Disability Determination

I understand that my records are protected under Federal and State confidentiality laws and regulations and may not be disclosed without my consent unless otherwise provided for by law or regulation. This authorization shall be effective for records and information created until this authorization expires or is revoked, even if such records and information are created after the date of signing this authorization. **This authorization gives the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information permission to discuss my medical records or treatment with the requesting representative.** I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and may then no longer be protected by federal privacy regulations. I understand that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment enrollment in a health plan, or eligibility for Long Term Care benefits on my decision to sign this authorization.

Your rights with respect to this authorization: **1) Right to inspect the health information to be used or disclosed-** I understand that I have the right to inspect my health information or obtain copies of my health information by contacting the health information department. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under sec. DHS 92.05 of the Wisconsin Administrative Code. **2) Right to refuse to sign-**I understand that I have the right to refuse to sign the authorization. **3) Right to receive a copy of this Authorization-** I understand that I have the right to receive a copy of this authorization. **4) Right to revoke this authorization-** I understand that written notification is necessary to revoke this authorization, and that I may revoke this authorization at any time. To obtain information on how to withdraw my authorization, I may contact my ADRC staff coordinating my services. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and /or organizations(s) above have made in reliance on this authorization.

Expiration Date: This authorization is good until the following date(s) _____ or for one year from the date signed, up to and including services dates created after the date of signature. I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I further acknowledge that this information to be released was fully explained to me and this consent is given of my own free will.

_____ _____

Signature of Client/Legal Representative Date

(If signed by other than the client, state relationship and authority in which to sign for client, i.e., deceased, minor, competent)

Request filed by _____ (employee) _____ (date)

A PHOTOCOPY OF THIS CONSENT IS AS VALID AS THE ORIGINAL