

CONSENT FOR RELEASE OF INFORMATION

1 I hereby authorize: Mental Health Center of Dane County, Inc.
625 West Washington Avenue, Madison, WI 53703-2637

2 To release information to: To obtain information from:
(Check one box or both. By checking both, you are authorizing an exchange of information between the agencies/individuals listed.)
Agency and/or individual _____
Street/City/State/Zip _____

3 From the records of:
Client name _____ Date of Birth _____
Other names used _____

4 Purpose or need for disclosure: *(check all that apply)*
 Service coordination Mental Health and/or substance abuse assessment/treatment
 Crisis management Other: _____

5 Types of information to be disclosed: *(check all that apply)* Developmental Disabilities HIV
 Mental Health Medical Educational
 Alcohol & Other Drug Human Services Other *(specify)* _____
Specific information to be disclosed: *(check all that apply)*
 Intake Summary Case Notes Assessments + Diagnoses
 Treatment Plans Progress Reports Clinical Impressions
 Discharge Summary Other *(specify)* _____

6 I understand that:
(a) My records are protected under State and Federal regulations governing confidentiality:
• Mental Health--Sec. 51.30, Wis. Stats.; & HFS 92, Wis. Admin. Code
• Alcohol & Other Drug Abuse--42 CFR, Part 2; Sec. 51.30, Wis. Stats.; & HFS 92, Wis. Admin. Code
• Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, pts 160 & 164
(b) I will receive a copy of this form and have the right to inspect/receive a copy of materials to be disclosed.
(c) Federal privacy law requires notification that my health information, once disclosed to individuals or organizations not subject to HIPAA, may no longer be protected by HIPAA. However, WI State statutes prohibit any individual or organization receiving information from my mental health or alcohol/other drug abuse treatment records from disclosing that information further without my written consent, unless otherwise provided for in the regulations.
(d) I am not required to sign this form and may refuse to do so. Except as permitted under applicable law, the Mental Health Center may not deny me services because I refuse to sign.
(e) I may revoke this consent at any time by giving written notice to my MHCDC service provider(s) or to the MHCDC Records Department, except to the extent that information has already been disclosed based on this release.

7 This consent (unless revoked earlier) expires on _____
(specify date, event or condition upon which expiration occurs).

Client Signature Date

Signature of Other Person Authorized to Consent (where applicable) Date

Relationship to Client

Witness Signature Date