Patient name			
MHN	DOB	Age	Gender

HOPE Consortium Care Coordination

Release of Information Authorization

Patient	Previous last name (if any) Address / Daytime phone number City / State / ZIP
Disclosure of protected health information to/ from/between	☐ **Forest County Potawatomi AODA Department** 5416 Everybody's Road, Crandon, WI 715-478-7200, Fax 715-478-7264 ☐ **Iron County Human Services** 300 Taconite Street, Suite #201, Hurley, WI 715-561-3636, Fax 715-561-2128 ☐ **Lac du Flambeau Chippewa Family Resource Center** 533 Peace Pipe Road, Lac du Flambeau, WI 715-588-3303, Fax 715-588-7930 ☐ **Family Health Center Alcohol and Drug Recovery Center – Minocqua** PO Box 1390, Minocqua, WI 715-358-1814, Fax 715-358-1188 ☐ **Ascension-Koller Behavioral Health** 1020 Kabel Avenue, Rhinelander, WI 715-361-2926, Fax 715-361-2420 ☐ **Options Counseling Service/ Koinonia Residential Treatment Center** 1991 Winnebago Street, PO Box 1550, Rhinelander, WI 715-362-5745, Fax 715-262-2819 ☐ **Price County Health and Human Services** 104 South Eyder Avenue, PO Box 88, Phillips, WI 715-339-2158, Fax 715-339-4018 ☐ **Sokaogon Chippewa Community Health Clinic AODA Program** 3144 VanZile Road, Crandon, WI 715-478-5180, Fax 715-478-7659 ☐ **The Human Service Center** (Forest, Oneida, and Vilas Counties) 705 East Timber Drive, PO Box 897, Rhinelander, WI 715-369-2215, Fax 715-369-4577 ☐ **HOPE Consortium Care Coordinators** (Marshfield Clinic Health System – Center for Community Outreach) PO Box 967, Minocqua, WI 715-358-6224, Fax 715-358-9539 ☐ _____ ☐ _____ ☐ _____
Reason for the disclosure	To allow the exchange of patient health information between providers involved in the care of the patient for purposes of treatment, payment, and health care operations.
Records to be disclosed Check (✓) box(es) of the records to be released per this request	Alcohol and other drug abuse records: ☐ Name and other personal identifying information ☐ Status as a patient in alcohol and/or drug treatment ☐ Initial evaluation ☐ Discharge date and discharge status ☐ Assessment results and history ☐ Summary of treatment, plan, progress and compliance ☐ Other, specify _____ OR ☐ All alcohol and other drug abuse ☐ Attendance ☐ Urinalysis results ☐ Other lab results ☐ Admission date ☐ Discharge plan
	Mental health/neuropsychology records: ☐ Mental health AND/OR ☐ Neuropsychology ☐ Other, specify _____

HOPE Consortium Care Coordination

Release of Information Authorization (Continued)

Patient name	MHN	DOB	Age	Gender

Reason for the release Check (✓) box to indicate the reason for the release per this request	☐ Care coordination or case management ☐ Other, specify _____
Expiration Check (✓) box to indicate the expiration per this request	This authorization will remain in effect for one year and will automatically expire on the _____ day of _____ , 20 _____ OR: ☐ Until you cancel this authorization in writing. ☐ Until the following event occurs, specify event _____ ☐ Other, specify _____

By signing this, you specifically authorize the use and disclosure of the information you selected above. You acknowledge that you have reviewed and understand this authorization form, including the notices below.

_____	_____	_____/_____/_____	_____
Patient signature (Patient's legal representative)	(Relationship)	Signature date (m/d/y)	Phone number

HOPE Consortium Care Coordination

Release of Information Authorization (Continued)

Patient name	MHN	DOB	Age	Gender

Your rights with respect to this authorization

Redisclosure notice to patient: If the person(s) and/or organization(s) listed on the front side are not health care providers, health care clearinghouses, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose your health information.

Disclosure notice to recipient of patient health care records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: This information has been disclosed to you from records whose confidentiality is protected by federal rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see Section 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to crime any patient with a substance use disorder, except as provided at Section 2.12(c)(5) and Section 2.65.

Your rights with respect to this authorization

- *Right to receive copy of this authorization* – You have the right to receive a copy of this authorization.
- *Right to refuse to sign this authorization* – You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may have the right to deny services if you refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. You will not be denied services if you refuse to consent to a disclosure for other purposes.
- *Right to withdraw this authorization* – You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact the Health Information Management (medical records) department. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have made prior to the receipt of your cancellation form. You understand that 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 policy or the policy itself.
- *Right to inspect a copy of the health information to be used or disclosed* – You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form. You may arrange to inspect your health information or obtain copies of your health information by contacting the Health Information Management (medical records) department.
- *HIV test results* – Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- *Mental health treatment records* – You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

