WRAPAROUND MILWAUKEE / REACH
AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

PURPOSE OF INFORMATION RELEASE/EXCHANGE:

Release / exchange of mental health (Enrollment notification and information, Plan of Care – including diagnosis/prognosis, and Progress Reports) AODA (Alcohol and Other Drug Addiction), physical health, school progress information and *Other documents that will be used to plan and provide for the care, treatment and services for:

_____ _____

(Youth's Name) **(Date of Birth)**

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and the Mobile Urgent Treatment Team to release and exchange information with staff at the agencies identified below. Information may be shared verbally or in writing.

AGENCY NAME / INDIVIDUAL NAME

1. **Agency/Individual** (please print):_____
   Address (please print): _____
   ****Identify Other Document/s:***

2. **Agency/Individual** (please print):_____
   Address (please print): _____
   ****Identify Other Document/s:***

3. **Agency/Individual** (please print):_____
   Address (please print):_____
   ****Identify Other Document/s:***

4. **Agency/Individual** (please print):_____
   Address (please print): _____
   ****Identify Other Document/s:***

EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION

If not specified below, I understand that this Authorization to Release/Exchange Information EXPIRES 12 MONTHS from the date it is signed. I understand that I may cancel this authorization at any time (see back of sheet for instructions). This cancellation does not include any information that has been shared between the time I gave my consent to share information and the time that the consent was canceled.

This authorization expires on the _____ day of _____, 20_____.

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.

_____ _____

Parent or Legal Guardian Signature **Date**

_____ _____

Youth Signature (*age 14 and older MUST sign)* **Date**

_____ _____

Witness Signature **Date**

PARTICIPANT RIGHTS RELATED TO AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

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.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment / service options available for my child or family. If my child is enrolled in Wraparound Milwaukee as part of a court order, I understand that failure to sign this form may result in a request to the courts to modify the court order that allows for enrollment in the Wraparound Milwaukee program.

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 Pamela Erdman, Wraparound Milwaukee Quality Assurance. (The statement must be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that Wraparound Milwaukee has made prior to receipt of my withdrawal statement

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 released/exchanged by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department**.**

HIV Test Results - I understand my child's HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

Submit your written requests for withdrawal to:

Ms. Pamela Erdman, Wraparound Milwaukee Quality Assurance Director
Wraparound Milwaukee Administrative Offices
9201 Watertown Plank Road
Milwaukee, WI 53226 Phone: (414) 257-7608