Milwaukee County DHHS-BHD
Children's Community Mental Health Services and Wraparound Milwaukee

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/Notes), AODA (Alcohol and Other Drug Addiction), physical health, billing information and school progress information that will be used to plan and provide for the care, treatment and services for:

Enrollee's Name:_____ Date of Birth:_____

I authorize Children's Community Mental Health Services and Wraparound Milwaukee, its contracted Care Coordination Agencies, and the Milwaukee County Mobile Crisis Team to release and exchange information with staff at the agencies identified below. Information may be shared verbally or in writing.

Place your initials in the box next to the agency name to authorize information release/exchange

	AGENCY NAME	ADDITIONAL INFO TO BE RELEASED/ EXCHANGED
	Insurance Carrier - Medicaid / Title 19 / Third Party Payer	
	Other Insurance Carrier Name:	
	Milwaukee County Behavioral Health Division/Programs	
	Division of Milwaukee Child Protective Services (DMCPS)	
	Youth and Family Justice Center/ Department of Youth & Family Services	
	Wisconsin State Public Defenders Office	
	Milwaukee County District Attorney's Office	
	The SEA Group (*Special Education Advocacy Agency*)	
	Milwaukee Public School District/ School Name:	
	Other School Name:	
	Primary Care Physician's Name: _____ Clinic Name/Address:	
	Other Name/Address:	

CONSENT FOR INFORMATION TO BE USED IN RESEARCH

I give my consent for non-identifying data obtained during my or my child's enrollment to be used for research to evaluate the effectiveness of the program. No information that is presented will contain any identifying personal information.

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/Legal Guardian's signature Date Enrollee's Signature (age 14 and older must sign) Date

_____ _____
Witness signature Date

CLIENT RIGHTS RELATED TO AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION:

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.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment/service options available for me, my child or family. If I/my child am/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 the removal of Wraparound Milwaukee from the court order.

Right to Refuse to Sign This Consent/Acknowledgement Form - I understand that I am under no obligation to sign this form and that Children's Community Mental Health Services and Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

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 used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Quality Assurance Department (414-257-7595).

HIV Test Results - I understand enrollee'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.

Right to Withdraw This Consent - I understand that I have the right to withdraw consent for any of the items identified on this Consent at any time by providing a written statement of withdrawal to the Quality Assurance Department. (The written statement must identify what Consent is being withdrawn, be dated and signed.) I am aware that my withdrawal will not be effective until received by Children's Community Mental Health Services and Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that was made prior to receipt of my withdrawal statement.

Submit your written request for withdrawal to:

Quality Assurance Manager
Children's Community Mental Health Services and Wraparound Milwaukee
9455 Watertown Plank Road
Milwaukee, WI 53226

ATTENTION: If you speak English, language assistance services are available to you free of charge. Call your Care Coordinator directly or call 1-833-912-2468 (TTY: 711)

Español (Spanish) - ATENCIÓN: Si habla español, tenemos servicios de asistencia lingüística disponibles de forma gratuita. Llame a su coordinador de atención directamente o bien llame al 1-833-912-2468 (TTY: 711)

Hmoob (Hmong) - CEEB TOOM: Yog koj hais lus Hmoob, muaj cov kev pab txhais lus pub dawb rau koj. Hu xov tooj ncaj nraim rau koj tus Neeg Khiav Hauj Lwm Muab Kev Kho Mob los yog hu rau 1-833-912-2468 (TTY: 711)

မွာ ျမန္မာစာ (Myanmar)(Burmese) - အထူးသတိျပဳရန္ - အကယ္၍ ျမန္မာဘာသာစကားကို သင္ေျပာဆိုႏိုင္ပါက ဘာသာစကားဆိုင္ရာ ဝန္ေဆာင္မွဳမ်ားကို အခမဲ့ သင္ ရရွိႏိုင္ပါသည္။ သင့္ ေစာင့္ေရွာက္မွဳ ဆက္စပ္ေဆာင္ရြက္ေပးသူထံသို႔ တိုက္ရိုက္ ဖုန္းေခၚဆိုပါ သို႔မဟုတ္လည္း 1-833-912-2468 (TTY: 711) သို႔ ေခၚဆိုပါ