



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, school progress information and *other documents that will be used to plan and provide for the care, treatment and services for:

Enrollee's Name: _____ **Date of Birth:** _____

I authorize Milwaukee County 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.

Agency Name/Individual Name

1. **Agency/Individual** (please print): _____

Address (please print): _____ **Phone:** _____

Email: _____ ***Identify Other Documents:** _____

2. **Agency/Individual** (please print): _____

Address (please print): _____ **Phone:** _____

Email: _____ ***Identify Other Documents:** _____

3. **Agency/Individual** (please print): _____

Address (please print): _____ **Phone:** _____

Email: _____ ***Identify Other Documents:** _____

4. **Agency/Individual** (please print): _____

Address (please print): _____ **Phone:** _____

Email: _____ ***Identify Other Documents:** _____

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

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)

မြန်မာစာ (Myanmar)(Burmese) - အထူးသတိပြုရန် - အကယူ။
ပြုမြန်မာဘာသာစကားကို သင့်ဝေါ်ဟနိုင်းဝိုင်းက ဘာသာစကားဆိုင်
ဝန်ဝေဆာင့်မှုးကို အခမဲ့ သင့်ရှိုးဝိုင်းသည့်။ သင့်ဝေါ်တောင့်ဝေါ်ကူး
ဆက်ပေးဆို၍ တိုကိုကုန်ဖော်ဆိုပါသို့။ မဟုတ်လည်း
1-833-912-2468 (TTY: 711) သို့၍ ဝေါ်ဆိုပါ