



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

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR FOSTER CARE

PURPOSE OF DISCLOSURE: Release of Mental Health, AODA (Alcohol and Other Drug Addiction) and physical health 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/or the Mobile Crisis Team to release/exchange health related information including diagnosis, prognosis, treatment and planning related to the above-named youth's enrollment in Children's Community Mental Health Services and Wraparound Milwaukee to the appropriate staff at the following agency/s:

AGENCY NAME / INDIVIDUAL NAME (Check all that apply)	SHARED DOCUMENTS/INFORMATION (Check all that apply)			
	<i>Demographic Information Only</i>	<i>Plan of Care</i>	<i>Referral for Services</i>	<i>Other (Please indicate below.)</i>
<input type="checkbox"/> Anu Family Services, Inc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Benevolence First, Inc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Children's Service Society of Wisconsin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Family Works Programs, Inc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fresh Start Counseling Center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Harmony Social Services CPA, Inc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> La Causa, Inc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> New Horizon Center, Inc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rawhide, Inc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> SaintA, Inc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> St. Charles Youth & Family Services, Inc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> THRIVE Treatment Services, LLC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
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Witness signature	Date		
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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၍
ပြုမြန်မာသာစကားကို သင့်ဝေါ်ဟနိုးဝိုင်းက သာသာစကားဆိုင်
ဝန်ဝေဆာင်းမှုးကို အခမဲ့ သင့် ရှိုးဝိုင်းသည့်။ သင့် ဝေစာင့်ဝေရှာကူး
ဆကုပ်ဝေဆာင်းပေးသုတေသန၏ တိုကိုကုန်ဝန်းဝေခင့်ခိုပါသို့ မဟုတ္တလည်း
1-833-912-2468 (TTY: 711) သို့ ဝေခင့်ခိုပါ