AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Participant Name: _____ Date of Birth: _____

Name of Parent/Guardian if Minor Child:_____

The above named person must indicate when this authorization is to expire by initialing the applicable box

	One time release/ when information is exchanged/released
	In one (1) month.
	In six (6) months.
	In one year (12 months).
	Other as detailed by participant.

The person named above hereby authorizes:
YOUR ORGANIZATION NAME HERE and/or Advocate or Representative
123 YOUR ADDRESS
YOUR ORG CITY, WI 11111
Ph: 111-111-1111 Fax: 111-111-1111

To: (initial)

	Request information from		Send information to
	Discuss information with		Receive information from

The Program/Representative as indicated below:

Name		
Provider/Agency	ORGANIZATION NAME	
Address	Organization Address, City, WI 111111	
Phone	111-111-1111	
Email		

Information To Be Released/Exchanged: (initial)

	Psychological Exam/Recommendations/Tx	Today's Date	From	To
	AODA Assessment/Recommendations/Tx	Today's Date	From	To
	Physical exam/history/recommendations	Today's Date	From	To
	Social Assessment/History		Criminal Complaint	
	Treatment Plan/Goals/Aftercare Plan		Batterers/ DV Assessment/Recommend..	
	Discharge Summary/Recommendations		Other:	
	General information regarding program participation.		Other:	

Purpose for the disclosure/release of information: (initial)

	In case of emergency notify contact person.		Coordinate services/s with other agency
	Facilitate family involvement in services.		(Other)

The above named participant has the following rights:

- This authorization is effective for the above requested and authorized information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this program. Your revocation will be honored except to the extent that has already been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be released.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. **We are not responsible for the actions of others** who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain services except to the extent that the information being requested may be needed to assist staff in determining appropriate service delivery.
- Unless otherwise specified by law, we will release only that information which has been created by this program, Advocate, or Representative of Agency: _____. Records created by and available from other providers must be obtained directly from those other providers or facilities.
- There may be a fee associated with the copying of your records. For personal use, you are entitled to one (1) copy of your requested information free of charge per release. Additional copies for you, future release to you, or releases to other providers, persons or facilities may be subject to a charge of: pages 1-9 free of charge; pages 10-19 ten cents per page (.10); pages 20 and more fifteen cents per page (.15). Contact the site administrator for additional information about applicable copying fees.

AUTHORIZATION

Printed Name of Participant:_____Date of Birth:_____

Participant Signature or Authorized Representative: _____Date:_____
Relationship of authorizing person to participant: _____Parent _____Guardian _____Other:_____

Staff Signature:_____Date:_____

Note to Recipient of Information

This information has been disclosed to you from records whose confidentiality is protected. You are prohibited from making any further disclosure of this information without the specific written consent of the person whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose.