



AUTHORIZATION FOR DISCLOSURE OF **SUBSTANCE USE DISORDER (SUD) TREATMENT RECORDS***

1100 Bergslien Street • Baldwin, WI 54002 • Health Information Management Department • Phone 715-684-1590 • Fax 715-684-1594

Patient Information:	Patient name: _____ Date of Birth: _____ Previous name(s): _____ MRN: _____ Address: _____ Phone: _____ City: _____ State: _____ ZIP: _____
Health Information Released FROM: <i>(Who has the information you want released?)</i>	Western Wisconsin Health Substance Use Disorder Treatment Program 1100 Bergslien Street Baldwin, WI 54002
Health Information Released TO: <i>(Where do you want the information sent?)</i>	Person/Organization: _____ Attn/Department: _____ Phone: _____ Address: _____ Fax: _____ City: _____ State: _____ ZIP: _____
Health Information to be Released: <i>(What information do you want sent or released? Check the appropriate box)</i>	Indicate date(s) of service: _____ Send CHECKED Records only: <input type="checkbox"/> Progress notes <input type="checkbox"/> Treatment Plans <input type="checkbox"/> Assessment/Intake records <input type="checkbox"/> Lab testing results <input type="checkbox"/> Discharge summary <input type="checkbox"/> Billing records <input type="checkbox"/> Medication records <input type="checkbox"/> Other: _____
Purpose of Disclosure: <i>(Why is it needed?)</i>	<input type="checkbox"/> Continuity/Transfer of Care <input type="checkbox"/> Personal use or review <input type="checkbox"/> Changing Clinics <input type="checkbox"/> Legal Proceedings/Attorney <input type="checkbox"/> Insurance or Disability Determination <input type="checkbox"/> Other: _____
Release Instructions: <i>(How and When do you want the information?)</i>	Date information is needed: _____ (NOTE: PLEASE ALLOW 7 BUSINESS DAYS FOR PROCESSING) <u>Delivery / Format method:</u> <input type="checkbox"/> Mail – Paper <input type="checkbox"/> Pick up – Paper <input type="checkbox"/> Fax – Paper <input type="checkbox"/> Mail – PDF on USB Drive <input type="checkbox"/> Pick up – PDF on USB Drive <input type="checkbox"/> MyChart – PDF sent to MyChart <input type="checkbox"/> Other: _____
<p>*This authorization applies to substance use disorder treatment records protected under 42 CFR Part 2, in addition to applicable HIPAA requirements.</p> <p>I have read and understand the following rights with respect to this authorization:</p> <ul style="list-style-type: none"> • This authorization will expire one year from the date of my signature unless I specify a different date or event here: _____ • I understand that I have the right to inspect or receive a copy of the information I have authorized to be disclosed. I may contact Western Wisconsin Health to request access to my records. • I understand that I am under no obligation to sign this authorization. I will be provided a copy of this signed authorization upon request. • I understand that I may revoke this authorization at any time by submitting a written request to Western Wisconsin Health. Revocation will not apply to information that has already been disclosed in reliance on this authorization. • I understand that Western Wisconsin Health may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. • I understand that information disclosed pursuant to this authorization may be protected by federal confidentiality rules (42 CFR Part 2), which limit further disclosure of my substance use disorder treatment information. • I have had an opportunity to review and understand the contents of this authorization form. By signing this authorization, I authorize Western Wisconsin Health to disclose the information described above. 	
<p>NOTICE OF PROHIBITION ON REDISCLOSURE</p> <p>This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.</p>	
Signature requirements:	_____ Patient/Legal Representative's Signature (include relationship if other than patient) Date