



Wellpoint Care Network Behavioral Health Clinic

MRN: _____
FOR OFFICE USE ONLY

Authorization for Use and Disclosure of Health or Confidential Information

1) Person Receiving Services:

Name: _____ Date of Birth: _____ Phone Number: _____
Address: _____ City, State, Zip: _____

2) Authorizes:

Wellpoint Care Network Behavioral Health Clinic
8901 W. Capitol Dr. Milwaukee, WI 53222
Phone: (414)465-5770 Fax: (414)260-8980



3) To: [] DISCLOSE [] OBTAIN [] EXCHANGE Information

4) With the following Individual/Agency/Organization(s):*separate authorizations are required if difference in use/disclosure details

Name: _____ Address: _____ City, State, Zip: _____ Phone Number: _____ Fax/Email: _____
Name: _____ Address: _____ City, State, Zip: _____ Phone Number: _____ Fax/Email: _____

5) Using Release Format(s): [] Verbal [] Paper [] Fax [] Email [] Mail [] Pick-up: Location _____ Picked up by: _____

6) Type of information authorized to disclose:

- [] Intake/Initial Assessment [] Appointment/Attendance [] Treatment Plan/Reviews
[] Care Coordination Notes [] Summary Psychosocial History [] Discharge Summary
[] Therapy Progress Reports [] Psychiatric/Psychological Evaluations [] Prescriptions/Medications
[] Financial Information [] Diagnostic Report [] Physical Examination
[] Face sheet [] All [] Other(specify) _____

7) In compliance with Wisconsin privacy statutes, we require special permission to release privileged information, please check any records pertaining to the following areas, you allow to be disclosed:

- [] Behavioral Health records/notes [] Alcohol/Drug Abuse Treatment (AODA) [] Developmental Disabilities
[] Sexually Transmitted Diseases [] HIV/AIDS

8) Purpose or need for information: [] Coordination of Care [] Education Planning [] Personal [] Legal [] Benefits
[] Other: _____

9) Dates of information to be disclosed: FROM: _____ TO: _____ [] Complete Record

10) Expiration: This authorization is good for one year from date of signature unless otherwise specified: _____

11) Rights Pertaining to This Authorization:

Right to Inspect: I understand I have the right to inspect or receive a copy of the confidential information I have authorized to be disclosed except for when not authorized by law. I may arrange to inspect this information or obtain copies by contacting the clinic. Right to Refuse Signature: I understand I am not required to sign this authorization and refusing to do so will not affect treatment, payment enrollment or benefits within state regulations, WI Statutes 51.30 and 252.15 requires client authorization to disclose health information for payment purposes, a refusal Right to Revoke: I may revoke this authorization at anytime by submitting a request in writing except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration date or one year from signature. Right to Receive a Copy: I understand if I agree to sign this authorization, I must be provided a copy. has the right to inspect and receive a copy of the material to be disclosed pursuant to this consent form. This authorization form is intended to be in conformance with Section 51.30(4)(d), Wisconsin Statutes and Sections HFS 92.03(3)(d) and 92.06, Wisconsin Administrative codes. HIV/AIDS Test Results: I understand my HIV test results may be released without an authorization to persons/organization that have access under state laws and a list of those persons/organizations is available upon request. Re-Disclosure Notice: I understand that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy law. The third party may not be required to abide by this Authorization or applicable Federal and State laws governing the use and disclosure of my health or confidential information. This information has been disclosed from records protected by Federal (42 CFR Part 2) and Wisconsin (51.30) confidentiality rules. The Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. A copy or facsimile (FAX) of this authorization will be considered valid as the original. If authorizing the use of FAX, I understand and accept the risks association with faxing confidential health information.

By signing this authorization, I am providing my informed consent to release the information outlined in this authorization. I have reviewed the contents of this authorization fully and it accurately represents my wishes.

Signature of Client: _____ Date: _____

Required for individuals 14 years and older.

If not signed by client, client is: [] Minor [] Unable to sign due to disability

Signature of Guardian/Legal Authority: _____ Date: _____

Required for individuals under 18 years of age

Signer is: [] Parent [] Legal Guardian [] Power of Attorney

Witness Signature: _____ Date: _____

Required when proof of legal authority is provided