

 WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 9/1/98	Reviewed: 9/27/12 By: PE Last Revision: 10/19/12	Section: ADMINISTRATION	Policy No: 011	Pages: 1 of 2 (3 Attachments)
☒ Wraparound ☒ Wraparound-REACH ☐ FISS ☐ Project O-Yeah	Effective Date: 1/1/13	Subject: CONSENT / ACKNOWLEDGEMENT AND AUTHORIZATION FORMS			

I. POLICY

It is the policy of Wraparound Milwaukee / REACH to have the youth and a parent/legal guardian sign the identified Consent/Acknowledgment and Authorization For Release of Information forms during the initial **face-to-face** contact that the Care Coordinator has with the family. The initial **face-to-face** contact must occur within the first seven (7) calendar days of enrollment (*first 5 working days*).

The purpose of the Consent/Acknowledgement Form is to receive permission from the youth and parent or legal guardian for the following:

- CONSENT/ACKNOWLEDGEMENT FORM (*see Attachment 1/1a for Spanish*) - to allow Wraparound Milwaukee /REACH personnel and/or providers/identified persons to transport youth, to acknowledge receipt of the Client Rights and Complaint/Grievance Procedure handout, and to acknowledge receipt of the Wraparound HIPAA Privacy Statement.

The purpose of the Authorization for Release of Information Form is to receive permission from the youth and parent/legal guardian for the following:

- AUTHORIZATION FOR RELEASE OF INFORMATION forms (*see Attachment 2/2a for Spanish*) - to allow Wraparound Milwaukee / REACH personnel to give or receive information with or from specific identified agencies/persons.

Note: *Also see Mobile Urgent Treatment Team (MUTT) Consent for Treatment Policy (#027).*

II. PROCEDURE

The Care Coordinator will receive the necessary Consent/Acknowledgement and Authorization for Release of Information Forms in the enrollment packet when they are assigned to work with a family.

The Care Coordinator is responsible for getting the necessary signatures during the first visit with the youth/family, which must occur during the first week of enrollment (*first 5 working days*).

Wraparound youth under the age of 14 (at admission) are not required to sign the Wraparound/REACH or MUTT Consent Forms. Youth age 14 and older should sign, but if a youth's signature cannot be obtained for whatever reason, the parent's/legal guardian's signature alone will suffice. If a youth is not 14 years of age when he/she enters the program, but turns 14 during the course of the first year in Wraparound, he/she should sign the Consents at the one year time frame when all Consents need to be renewed/resigned.

Note: *Exchange of information and formal Wraparound / REACH services cannot legally occur without the forms being signed.*

The Forms must then become a permanent part of the youth's file. Copies must be shared with identified parties as information needs to be shared/given/received.

All Consent/Acknowledgement and Authorization forms expire 12 months from the date they were signed and then every subsequent 12 months. Therefore, Consents need to be signed at enrollment, 12 months, 24 months, 36 months, etc. Consents and Authorizations can be canceled/revoked at any time. This must be done in writing.

WRAPAROUND MILWAUKEE

Consents Policy

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Requests to revoke and refusals to sign Consent or Authorization forms are to be immediately forwarded for processing to the Wraparound Quality Assurance Director, as identified on the form.

A. Consent/Acknowledgement Form.

1. The Care Coordinator is responsible for explaining each item on the Consent/Acknowledgement form.
2. The parent/guardian, and the youth if they desire, should initial each item. This signifies consent to that item or acknowledgment of receipt of the Client Rights and Complaint/Grievance Procedure handout, and Wraparound HIPAA Privacy Statement.
3. The Care Coordinator is to offer an overview of the Client Rights and Complaint/Grievance Procedure information contained in the Clients Rights and Complaint/Grievance Procedure handout and answer any questions that the youth or family might have.
4. The Care Coordinator is to offer an overview of the Wraparound HIPAA Privacy Statement and answer any questions that the youth or family might have.
5. The signed Consent/Acknowledgement Form is to be placed in the client record in the Intake/Consents Section.
6. **Upon Request**, a copy of the form is to be given to the legal guardian/youth (per HFS 9403(3)).

B. Authorization for Release of Information Form.

1. The Care Coordinator is responsible for explaining that signing the Authorization for Release of Information Form allows Wraparound Milwaukee to exchange information with the agencies/persons listed on the form. The family may withdraw the authorization to release information by submitting a written request to the Wraparound Quality Assurance Director, as identified on the form.
2. A copy of the Authorization for Release of Information Form **must be given to the family**. This form will be completed and signed at enrollment by the Wraparound Milwaukee Initial Assessment Worker.
3. Copies must also be shared with parties identified as receiving/exchanging information.
4. Additional Authorization for Release of Information Forms must be completed for new service providers (*see Attachment 3*). For example, if a new service Provider is introduced and is not listed on the original Authorization for Release of Information Form, another form must be completed and signed/dated by the parent/legal guardian before the Care Coordinator can release/exchange information or make referrals to that Provider.
5. After the form(s) is(are) signed, the Authorization for Release of Information Form becomes a permanent part of the client record and should be placed in the Intake/Consents Section. Upon completion of the Release of Information form, the Care Coordination Agency clerical support staff will also indicate in Synthesis (*Wraparound Milwaukee's IT system*) those individuals/agencies/community resources that are listed on the form for which the family has given permission for Wraparound Milwaukee to release/exchange information with.

Reviewed & Approved by: _____



Bruce Kamradt, Director



WRAPAROUND MILWAUKEE CONSENT/ACKNOWLEDGEMENT FORM

The following items are essential to the care of you and/or your family while participating in Wraparound Milwaukee and its programs. Please review each area and indicate which areas you approve by initialing the appropriate line after each heading.

Initial to Approve

**1. ACKNOWLEDGEMENT OF RECEIPT OF CLIENTS RIGHTS
& COMPLAINT/GRIEVANCE PROCEDURE**

I have read and understand my legal client rights as a participant of a Wraparound Milwaukee programs and recipient of services provided through the Provider Network. By signing below I acknowledge that I have received a copy of the "Client Rights and Grievance Procedure" handout.

2. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY STATEMENT

I have received, read and understand the Privacy Statement, and understand the program's commitment to protecting any identifiable client information as mandated by law.

3. CONSENT FOR TRANSPORTATION

I hereby give my consent for me and/or my children to be transported by Wraparound Milwaukee program staff and its agents as needed.

Unless otherwise specified below, this consent will expire 12 months from the date it was signed. This consent or any part of this consent may be canceled at any time with written notification as outlined on the back of this form.

Enrollee Name (please print) Date of Birth (Date, event or condition upon which consent will expire)

Parent or Legal Guardian's Signature (required if enrollee under age 18) Date

Enrollee's Signature Date

Witness Signature Date

YOUR RIGHTS WITH RESPECT TO THIS CONSENT:

Right to Refuse to Sign This Consent/Acknowledgement Form - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

Right to Withdraw This Consent - I understand that I have the right to withdraw consent for any of the items identified on the previous page at any time by providing a written statement of withdrawal to Pamela Erdman, Wraparound Quality Assurance. (The statement must identify what Consent that is being withdrawn, be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee.

Submit your written request for withdrawal to: Ms. Pamela Erdman, Quality Assurance Director
Wraparound Milwaukee
9201 Watertown Plank Road
Milwaukee, WI 53226
(414) 257-7608

**FORMA DE CONSENTIMIENTO/RECONOCIMIENTO**

Los siguientes artículos son esenciales para el cuidado de su familia mientras estén participando en el programa *Wraparound Milwaukee*. Por favor de revisar cada una de las áreas e indique cuales áreas usted aprueba iniciando la línea apropiada después de cada título.

Las Iniciales para Aprobar**1. CONSENTIMIENTO PARA TRANSPORTACIÓN**

Doy mi consentimiento para que mi(s) hijo(s) sean transportados por *Wraparound Milwaukee* y sus agentes así como sea necesario.

2. RECONOCIMIENTO DE HABER RECIBIDO LOS DERECHOS DEL CLIENTE & EL PROCEDIMIENTO DE QUEJAS/AGRAVIO

He leído y entiendo mis derechos legales como cliente y como participante del programa *Wraparound Milwaukee* y recipiente de servicios proporcionados a través de la Red de Proveedores Integrados de *Wraparound*. Al firmar abajo confirmo que he recibido una copia de "Los Derechos del Cliente y el folleto del Procedimiento de Agravio."

3. RECONOCIMIENTO DE HABER RECIBIDO LA DECLARACIÓN DE PRIVACIDAD

He recibido, leído y entiendo la Declaración de Privacidad de *Wraparound Milwaukee*, y entiendo el compromiso de proteger cualquier información que identifique al cliente como esta ordenado por la ley.

A menos que se especifique lo contrario abajo, este consentimiento expirará 12 meses de la fecha en que se firmo. Este consentimiento o cualquier parte de este consentimiento pueden ser cancelados en cualquier momento con notificación por escrito como esta planteado en la parte de atrás de esta forma.

(Nombre del Joven)

(Fecha de Nacimiento)

(Fecha, evento o condición por el cual este consentimiento expirará)

Firma del Padre o Tutor Legal

Fecha

Firma del Joven (14 años de edad y mayores deben firmar)

Fecha

Firma del Testigo

Fecha

Consent -Acknowledgement Form 9/04Revised 11/9/05 - DDJ

SUS DERECHOS CON RESPECTO A ESTE CONSENTIMIENTO:

Derecho a Negarse a Firmar Esta Forma de Consentimiento/Reconocimiento – Entiendo que no estoy bajo ninguna obligación de firmar esta forma y que *Wraparound Milwaukee* no puede limitar tratamiento, pago, o matrícula por mi decisión de firmar esta autorización.

Derecho a Retirar Este Consentimiento – Entiendo que tengo derecho a retirar mi consentimiento por cualquier razón identificada en la pagina anterior en cualquier momento al proveer una declaración escrita de retiro a Pamela Erdman, Servicios de Control de Calidad. (La declaración debe identificar el consentimiento que se va a retirar, ser fechado y firmado). Entiendo que mi retiro no será efectivo hasta que sea recibido por *Wraparound Milwaukee*.

Entregue su solicitud de retiro por escrito a:

Ms. Pamela Erdman
Quality Assurance Director
Wraparound Milwaukee
9201 Watertown Plank Road
Milwaukee, WI 53226
(414) 257-7611

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) AODA (Alcohol and Other Drug Addiction), physical health and school progress information that will be used to plan and provide for the care, treatment and services for:

(Youth's Name)

(Date of Birth)

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and the Mobile Urgent Treatment Team to release and exchange information with staff at the agencies identified below. Information may be shared verbally or in writing.

Place your initials in the box next to the agency name to authorize information release/exchange.

<u>AGENCY NAME</u>	<u>ADDITIONAL INFO. TO BE RELEASED/EXCHANGED</u>
☐ Insurance Carrier - Medicaid / Title 19	_____
☐ Insurance Carrier – Other _____ (Insurance Company Name)	_____
☐ Bureau of Milwaukee Child Welfare	_____
☐ Milwaukee County Children's Court	_____
☐ Wraparound Education Advocates Chris Shafer, Laverne Lunde, Shirley Fishman	_____
☐ Families United of Milwaukee, Inc. (Family Advocacy Agency)	_____
☐ Milwaukee Public Schools _____ (School Name)	_____
☐ Other Schools _____ (School Name)	_____
☐ Primary Care Physician _____ (Physician)	_____
☐ _____ (Clinic Name /	_____
☐ Other-Name _____	_____
Address: _____	_____

☐ Youth in Wraparound and REACH are also encouraged to participate in our **Wraparound Youth Council and Clubhouse** activities. By initialing here you authorize Youth Council representatives to contact your child directly regarding activities and events.

CONSENT FOR INFORMATION TO BE USED IN RESEARCH

I give my consent for non-identifying data obtained during my enrollment to be used for research to evaluate the effectiveness of the program. No information that is presented will contain any identifying personal information.

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_____.

REDISCLASURE 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

Youth Signature (age 14 and older should sign)

Date

Witness Signature

Date

PARTICIPANT RIGHTS RELATED TO AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

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.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment / service options available for my child or family. If my child 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 enrollment in the Wraparound Milwaukee program.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Pamela Erdman, Wraparound Milwaukee Quality Assurance. (The statement must be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that Wraparound Milwaukee has made prior to receipt of my withdrawal statement

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 released/exchanged by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department.

HIV Test Results - I understand my child'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.

Submit your written requests for withdrawal to:

Ms. Pamela Erdman, Wraparound Milwaukee Quality Assurance Director
Wraparound Milwaukee Administrative Offices
9201 Watertown Plank Road
Milwaukee, WI 53226 Phone: (414) 257-7608

AUTORIZACIÓN PARA HACER LA INFORMACIÓN PÚBLICA

PROPÓSITO DE DIVULGACIÓN:

Hacer pública información de Salud Mental y AODA (Alcohol y Otras Adicciones a Drogas) y de de salud física la cual será utilizada para planificar y proveer para el cuidado, tratamiento, y servicios para:

(Nombre del Joven)

(Fecha de Nacimiento)

Yo autorizo a Wraparound Milwaukee, sus agencias de contrato de coordinación de cuidado, y/o el Equipo Urgente Móvil del Tratamiento Para sacar/intercambiar información relacionado con la salud incluyendo diagnóstico, pronóstico, de tratamiento y planificación relacionado con el nombre de la parte superior del joven en Wraparound Milwaukee para el personal apropiado y las siguientes agencias que autoricen inscripción o proveen servicios de emergencias para familias alistadas en el programa de Wraparound Milwaukee.

• Corte de los niños del condado de Milwaukee • Medicaid/Título 19 • Oficina del bienestar del niño de Milwaukee
Además, yo autorizo soltar de información relacionado al nombre del joven de la parte superior para las siguientes agencias identificadas a la parte de abajo para el propósitos de planificar para y de la entrega del cuidado medico mental en curso, del cuidado medico físico y de los servicios de la educación.

PONGA UNA "X" EN LA CAJA AL LADO DEL NOMBRE DE LA AGENCIA PARA AUTORIZAR INFORMACIÓN SOLTADA

NOMBRE DE LA AGENCIA

- ☐ Familias Unidas de Milwaukee, Inc. (abogado de la familia)
**Chris Shafer, Kay
Frederick, Shirley Fishman**
- ☐ Abogado de la Educación de Wraparound _____
(Entre Nombre de la Escuela)
- ☐ Escuelas Publicas de Milwaukee _____
(Entre Nombre de la Escuela)
- ☐ Otra Escuela _____
(Entre Nombre de la Escuela)
- ☐ Medico Primario del cuidado _____
(Entre el nombre del medico o de la clínica)
- ☐ Proveedor de Servicios Dental _____
(Entre el Nombre del Dentista o de la clínica)
- ☐ Siquiatra _____
(Entre el Nombre del medico o de la clínica)
- ☐ Otro _____
(Entre el Nombre de la agencia o del proveedor)

INFORMACION QUE PUEDE SER LANZADA

- Información Democrática solamente
- Plan de cuidado, Diagnostico, del progreso y de los informes de la escuela
- Plan de cuidado, Diagnostico, del progreso y de los informes de la escuela
- Plan de cuidado, Diagnostico, del progreso y de los informes de la escuela
- Plan de cuidado, Diagnostico, y informes de progreso
- Plan de cuidado, Diagnostico, y informes de progreso
- Plan de cuidado, Diagnostico, y informes de progreso
- Plan de cuidado, Diagnostico, y informes de progreso

CONSENTIMIENTO PARA QUE LA INFORMACION SE USADA EN LA INVESTIGACION

Yo doy mi consentimiento para los datos de la evaluación no-que identifican obtenidos durante mi inscripción en Wraparound que se utilizara para la investigación para evaluar la eficacia del programa. Yo entiendo que la investigación puede ser presentada en conferencias, universidades y en publicaciones. Yo entiendo que la información recogida para la investigación es parte de los procedimientos generalmente de la evaluación de Wraparound. Yo entiendo que el confidencial de mi familia será protegido. Ninguna información que es presentada al público contendrá cualquier información que identifica tal como nombre, dirección o número de teléfono.

EXPIRACION DE AUTORIZACION / RETIRO DE LA AUTORIZACION

Si no especificado abajo, yo entiendo que esta Autorización para el lanzamiento de información EXPIRA en 12 meses a partir de la fecha que fue firmado. Yo entiendo que puedo cancelar esta autorización en cualquier momento (véase detrás de la hoja para las instrucciones). Esto no incluye ninguna información que se haya compartido entre el tiempo que di mi consentimiento a la información de la parte y al tiempo que el consentimiento fue cancelado.

Esta autorización expira en _____ día del _____, 20_____.

AVISO DE REVELACION: Yo entiendo que la información que se utilizo o se revelo basado en la autorización puede estar conforme a re-acceso y protegido no más por estándares federales del aislamiento.

Firma del Padre o Guardián Legal

Día

Firma del Joven (edad de 14 años o mayor debe firmar)

Día

LOS DERECHOS DEL CLIENTE RELACIONADOS CON LA AUTORIZACION DE LANZAMIENTO DE INFORMACION

SUS DERECHOS CON RESPECTO A ESTA AUTORIZACION:

El derecho de recibir una copia de esta Autorización – Yo entiendo que si firmo esta autorización, yo seré proporcionado una copia de esta autorización.

Derecho a Rechazar a Firmar esta Autorización – Yo entiendo que no estoy bajo ninguna obligación de firmar esta forma y que el Wraparound Milwaukee no puede condicionar el tratamiento, el pago, o la inscripción en mi decisión de firmar esta autorización.

Falta de Firma – Yo entiendo que la falta de firmar esta autorización puede limitar seriamente las opciones del tratamiento/de servicios disponibles para mi niño o familia y/o puede dar lugar a una petición a las cortes de modificar el orden judicial que permite la inscripción en el programa de Milwaukee del Wraparound.

Derecho a Retirar esta Autorización – Yo entiendo que tengo el derecho de retirar esta autorización en cualquier momento proporcionando una declaración escrita del retiro a Pamela Erdman, garantía de calidad de Milwaukee del Wraparound y no será eficaz con respeto a las aplicaciones y/o los accesos de mi información de la salud que Wraparound Milwaukee a hecho antes de recibo de mi declaración de retiro.

Derecho a Examinar o Copiar la Información de la Salud que se Utilizara o Divulgara – Yo entiendo que tengo el derecho de examinar o de copiar (puede ser proporcionado en una razonable cuota) la información de la salud que he autorizado para ser utilizado o para ser divulgado por esta forma de la autorización. Puedo arreglar para examinar mi información de la salud e obtener copias de mi información de la salud entrando en contacto con Pamela Erdman en el departamento de la garantía de calidad de Milwaukee Wraparound.

Resultado de la prueba de HIV – Yo entiendo que los resultados de la prueba de HIV de mi niño se pueden lanzar sin la autorización a las personas/a las organizaciones que tienen acceso bajo la ley del estado y una lista de esas personas/organizaciones esta disponible a petición.

Someta sus peticiones escritas para el retiro a:

Ms. Pamela Erdman, Directora de la garantía de calidad de Wraparound Milwaukee
Oficinas Administrativas de Wraparound Milwaukee
9201 Watertown Plank Road
Milwaukee, WI 53226 Teléfono: (414) 257-7608

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) 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:

(Youth's Name)

(Date of Birth)

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and the Mobile Urgent Treatment 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): _____

*Identify Other Document/s: _____

2. Agency/Individual (please print): _____

Address (please print): _____

*Identify Other Document/s: _____

3. Agency/Individual (please print): _____

Address (please print): _____

*Identify Other Document/s: _____

4. Agency/Individual (please print): _____

Address (please print): _____

*Identify Other Document/s: _____

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

Youth Signature (age 14 and older should sign)

Date

Witness Signature

Date

PARTICIPANT RIGHTS RELATED TO AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

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.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment / service options available for my child or family. If my child 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 enrollment in the Wraparound Milwaukee program.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Pamela Erdman, Wraparound Milwaukee Quality Assurance. (The statement must be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that Wraparound Milwaukee has made prior to receipt of my withdrawal statement

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 released/exchanged by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department.

HIV Test Results - I understand my child'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.

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Ms. Pamela Erdman, Wraparound Milwaukee Quality Assurance Director
Wraparound Milwaukee Administrative Offices
9201 Watertown Plank Road
Milwaukee, WI 53226 Phone: (414) 257-7608