COMPREHENSIVE COMMUNITY SERVICES (CCS)
RELEASE OF INFORMATION

I, _____, hereby authorize Milwaukee County Behavioral Health Division, Community Access to Recovery Services and/or Children's Mental Health Services and Wraparound Milwaukee to release the following information or reports from my medical records.

Excerpts from psychological, physical, social and financial data. Diagnosis, prognosis, treatment and treatment plans for physical and/or emotional illness and alcohol and drug abuse.

To: **Milwaukee County Department of Health and Human Services and Wisconsin Department of Health Services**

For the purposes of applying for and/or obtaining services coordinated through the Comprehensive Community Services (CCS) benefit.

I will also authorize release of information from my case records necessary for program monitoring and evaluation to the designated Comprehensive Community Services review team in the Wisconsin Department of Health Services. I understand that the disclosure of this information will not affect my eligibility for services or to be used to identify me personally.

I understand that I have the right to inspect and receive a copy of the material disclosed.

I understand that I may revoke this consent at any time.

This consent will expire one year from the date signed.

Signature acknowledges the receipt of and understanding of the materials listed above.

Participant Signature:_____**Date**:_____

***Parent/Legal Guardian Signature**:_____**Date**:_____

***Parent/Legal Guardian printed name:**_____

For staff use below:

Agreement reviewed by:_____**Date received**:_____

*Under 14 does not require participant signature, only parent/legal guardian. 14-17 requires both participant and parent/legal guardian signature. 18+ requires participant signature or legal guardian signature if applicable.