Milwaukee County DHHS-BHS
Children's Community Mental Health Services and Wraparound Milwaukee

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR FOSTER CARE

PURPOSE OF DISCLOSURE: Release of Mental Health, AODA (Alcohol and Other Drug Addiction) and physical health information that will be used to plan and provide for the care, treatment and services for:

Enrollee's Name:___________________________________ **Date of Birth:**______________

I authorize Children's Community Mental Health Services and Wraparound Milwaukee, its contracted Care Coordination Agencies, and/or the Mobile Crisis Team to release/exchange health related information including diagnosis, prognosis, treatment and planning related to the above-named youth's enrollment in Children's Community Mental Health Services and Wraparound Milwaukee to the appropriate staff at the following agency/s:

AGENCY NAME / INDIVIDUAL NAME (Check all that apply)		**SHARED DOCUMENTS/INFORMATION** (Check all that apply)			
		Demographic Information Only	*Plan of Care*	*Referral for Services*	*Other (Please indicate below.)*
☐	Anu Family Services, Inc.	☐	☐	☐	☐
☐	Benevolence First, Inc.	☐	☐	☐	☐
☐	Children's Service Society of Wisconsin	☐	☐	☐	☐
☐	Fresh Start Counseling Center	☐	☐	☐	☐
☐	Helping Others Prosper Everyday	☐	☐	☐	☐
☐	La Causa, Inc.	☐	☐	☐	☐
☐	New Horizon Center, Inc.	☐	☐	☐	☐
☐	St. Charles Youth & Family Services, Inc	☐	☐	☐	☐
☐	THRIVE Treatment Services, LLC	☐	☐	☐	☐
☐	Wellpoint Care Network, Inc.	☐	☐	☐	☐
☐	Wisconsin Community Services, Inc.	☐	☐	☐	☐
☐	Other:	☐	☐	☐	☐

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/Legal Guardian's signature | Date | Enrollee's Signature (age 14 and older must sign) | Date

_____________________________ ___________
Witness signature | Date

CLIENT RIGHTS RELATED TO AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION:

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.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment/service options available for me, my child or family. If I/my child am/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 the removal of Wraparound Milwaukee from the court order.

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

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 used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Quality Assurance Department (414-257-7600).

HIV Test Results - I understand enrollee'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.

Right to Withdraw This Consent - I understand that I have the right to withdraw consent for any of the items identified on this Consent at any time by providing a written statement of withdrawal to the Quality Assurance Department. (The written statement must identify what Consent is being withdrawn, be dated and signed.) I am aware that my withdrawal will not be effective until received by Children's Community Mental Health Services and Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that was made prior to receipt of my withdrawal statement.

Submit your written request for withdrawal to:

Quality Assurance Manager
Children's Community Mental Health Services and Wraparound Milwaukee
1220 W Vliet Street, 3rd Floor
Milwaukee, WI 53205
wrapqa@milwaukeecountywi.gov

ATTENTION: If you speak English, language assistance services are available to you free of charge. Call your Care Coordinator directly or call 1-833-912-2468 (TTY: 711)

Español (Spanish) - ATENCIÓN: Si habla español, tenemos servicios de asistencia lingüística disponibles de forma gratuita. Llame a su coordinador de atención directamente o bien llame al 1-833-912-2468 (TTY: 711)

Hmoob (Hmong) - CEEB TOOM: Yog koj hais lus Hmoob, muaj cov kev pab txhais lus pub dawb rau koj. Hu xov tooj ncaj nraim rau koj tus Neeg Khiav Hauj Lwm Muab Kev Kho Mob los yog hu rau 1-833-912-2468 (TTY: 711)

မြန်မာစာ **(Myanmar) (Burmese)** - အထူးသတိပြုရန် - အကယ်၍ မြန်မာဘာသာစကားကို သင်ပြောဆိုနိုင်ပါက ဘာသာစကားဆိုင်ရာ ဝန်ဆောင်မှုများကို အခမဲ့ သင် ရရှိနိုင်ပါသည်။ သင့် စောင့်ရှောက်မှု ဆက်စပ်ဆောင်ရွက်ပေးသူ ထံသို့ တိုက်ရိုက် ဖုန်းခေါ်ဆိုပါ သို့မဟုတ်လျှင်လည်း 1-833-912-2468 (TTY: 711) သို့ ခေါ်ဆိုပါ။

Chinese注意：如果**您使用中文，那么您可以免**费获得语言协助服务。请直接联系您的护理协调员，或致电 1-833-912-2468 (TTY: 711)。