



# Milwaukee County Housing Division

## AUTHORIZATION FOR RELEASE OF INFORMATION

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize: \_\_\_\_\_

To release information to: Milwaukee County Housing Division, 600 W. Walnut Street, Suite 100  
Milwaukee, WI 53212

**THIS AUTHORIZATION IS RECIPROCAL** (meaning, the disclosing party and recipient(s) may mutually exchange the information noted below via paper and/or electronic medical record.)

I understand that the information may include diagnosis, prognosis, and/or treatment for physical illness, mental health disorders, alcohol or drug abuse, any HIV test results and/or AIDS-related diagnosis.

Personal Identifying Information: Name (First, Middle and Last), Social Security Number, Date of Birth, Ethnicity, Gender, Last Residence Information, Military Status. • Housing/Program Specific: Entry/Exits, Agency Assessments, Services, Coordinated Entry, Case Notes, Referrals. • Assessment Specific: Income, Non-cash Benefits, Disability, Domestic Violence.

The information to be disclosed may be verbal and/or written and can include:

- Alcohol/Drug Abuse Assessment
- Discharge Instructions
- Discharge Summary
- History & Physical
- Psychiatric Evaluation
- Psychosocial Assessment
- Lab Results
- Medications/Medication Profile
- Progress Notes
- Outpatient Mental Health/AODA records
- Legal Status/Court Records
- Other (specify) \_\_\_\_\_

\*A photocopy of facsimile of this authorization shall be as valid as the original.\*

Prohibition On Disclosure (for AODA records): This information is protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit 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 42 CRR, 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 an alcohol or drug abuse patient. I also understand that I may inspect and, upon payment of the usual fee, receive a copy of the released information, and that I may receive a copy of this intended consent form.

Effect of Granting this Authorization: The protected health information described above may be disclosed and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Representative (legal documentation required)

\_\_\_\_\_  
Date