Wisconsin Community Services
Hub & Spoke Health Home
2620 W. North Ave Milwaukee, WI 53210

Email: healthomeinfo@wiscs.org
Phone: 414-914-9494
Fax: 414-416-3944

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Member: _____ **DOB:** _____

Address: _____ **Phone**: _____

City, State, ZIP: _____ **Email**: _____

I hereby consent and authorize the release of my Protected Health Information (PHI) as described herein between Wisconsin Community Services, Inc. (WCS) and the individual/organization listed below. I understand that this authorization is voluntary. I understand that based on the information entered below I authorize WCS to disclose and/or receive the PHI indicated to/with the individual/organization listed below.

I authorize Wisconsin Community Services, Inc. to: ☐ Send To ☐ Receive From ☐ Both
I authorize disclosure to occur in the following formats: ☐ Written ☐ Verbal ☐ Both

Person/Agency: _____ **Phone**: _____

Address: _____ **Fax**: _____

City, State, ZIP: _____ **Email**: _____

For the following purpose or need *(Please check specifics):*

☐ Request of Individual ☐ Legal/Criminal Justice ☐ Verification of Services ☐ Collateral Information
☐ Coordination of Care ☐ Follow Up/Transition of Care ☐ Research/Program Evaluation ☐ Insurance/Billing
☐ Other *(please list)*: _____

The disclosure of the following specific information is authorized (*Please check specifics):*

☐ Demographic Information ☐ Assessment Summary ☐ Services/Providers ☐ Diagnosis
☐ Dates & Nature of Contacts ☐ Current Treatment Services ☐ Substance Use History ☐ Discharge Summary
☐ Insurance & Billing Information ☐ Treatment/Care Plans ☐ UDS/UA & PBT Results ☐ Treatment History
☐ Psychosocial Assessment ☐ BAM, Acuity, & Screen Results ☐ Medications
☐ Other *(please list)*: _____

This disclosure is valid through the following dates: _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

This authorization expires 1 year from date signed or on date listed above, but can be revoked at any time prior, unless section 2.35 of 42 CFR Part 2 applies. I make this consent with the guarantee that any written information disclosed under the covenant of this document will be accompanied by a notice where applicable, which states: "This information has been disclosed to you from records whose confidentiality is protected by Federal regulations (42 CFR Part 2) which prohibit any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization of the release of medical or other information is NOT sufficient for this purpose." An oral disclosure may be accompanied by or followed by such a notice.

_____ _____
Member/Subject of Record Signature Date

_____ _____
Witness Signature Date

_____ _____
Signature of Parent and/or Guardian (if applicable) Date