DEPARTMENT OF CHILDREN AND FAMILIES
Division of Family and Economic Security

ROI

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

The provision of your Social Security Number (SSN) is mandatory under Wisconsin Statutes 49.145 (2)(k). Your SSN may be verified through computer matching programs and may be used to monitor compliance with program regulations and program management. Your SSN may be disclosed to other Federal and State Agencies for official examination. If you do not provide your social security number, your application for benefits will be denied.

Regarding the records of:

Name (Last, First, MI)

Date of Birth	Social Security Number (SSN)	PIN

Address	City	State	Zip Code

I hereby authorize the disclosure of any confidential information I provide or that is otherwise obtained about me to the Department of Children and Families (DCF), W-2 Program which includes subcontracted providers that DCF contracts with to provide direct case management services. I also agree that information about my condition and/or treatment may be communicated among personnel at these offices who have a need for the information in connection with their duties. Wisconsin Statute 51.30 (4)(d), Wisconsin Administrative Code HHS 92.03 (3), 92.06, and 42 CFR Part 2.

I hereby authorize and request:

W-2, County or Tribal Human/Social Services Agency (DCF contracted provider)	Telephone Number ( )		
Address	City	State	Zip Code

☐ **Disclose to** ☐ **Receive from** ☐ **Or exchange information with**

Name of Agency/Organization/Person	Telephone Number ( )		
Address	City	State	Zip Code

This information is needed for eligibility determination/continuation, the development/revision of the above named individual's Employability Plan. This information could also include the progress summaries, attendance verification, and/or establishment of good cause for non-cooperation with child support requirements.

Type or extent of information to be disclosed (Check all records that you wish to be released.)

☐ Psychiatric/Mental Health
☐ Legal
☐ Financial
☐ Alcohol and Drug
☐ School Attendance
☐ Medical
☐ Domestic Violence
☐ Specific Request _____

	Psychiatric Evaluation including Diagnosis/Prognosis		Medical Reports/Physical Exams including Diagnosis/Prognosis
	Psychiatric/Psychotherapy Progress Summaries		Urinalysis Results
	Psychological Evaluation		Treatment Plans
	Alcohol/Drug Initial Assessment/Evaluation		Psychosocial History
	Attendance Records		AODA Progress Summaries
	Bank Records		Employment Records
	Legal Records		

I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. This authorization will automatically expire one year from the date of signature unless indicated and initialed below.

_____ Authorization expires as of _____/_____/_____ (Date)

_____ Authorization expires after the following action takes place:_____

Copies to: Disclosing Agency, Participant, Case Record

RETAIN COMPLETED FORM IN CASE RECORD

As evidenced by my signature below, I hereby authorize the disclosure of records to the person or agency as specified.

THIS FORM MUST BE SIGNED AND DATED BY THE PARTICIPANT (OR A PERSON LEGALLY AUTHORIZED TO DISCLOSE FOR THE PARTICIPANT) AND A WITNESS FROM THE W-2, COUNTY OR TRIBAL HUMAN/SOCIAL SERVICES AGENCY FOR THE DISCLOSURE OF THE REQUESTED INFORMATION TO OCCUR.

Participant Signature	Date Signed
Person Legally Authorized to Disclose for the Participant Signature	Date Signed
Agency Witness Signature	Date Signed

THE FOLLOWING APPLIES TO YOU ONLY IF THE RECORDS AUTHORIZED FOR RELEASE ON REVERSE SIDE RELATE TO YOUR TREATMENT FOR MENTAL ILLNESS, DEVELOPMENTAL DISABILITIES, ALCOHOL, OR DRUG ABUSE:

The patient who is the subject of the records covered by this authorization, in most cases, has the right to inspect and receive a copy of the material to be disclosed pursuant to this consent form. Except for records of medication and somatic treatment, this right may be denied by the treatment facility director, or designee, during the patient's treatment under certain circumstances. A uniform and reasonable fee may be charged for a copy of the records. The fee may be reduced or waived in accordance with agency policy for those patients who show an inability to pay.

This information has been disclosed to the DCF contracted W-2 provider *(the W-2, County or Tribal Human/Social Services Agency)* from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you *(the W-2, County or Tribal Human/Social Services Agency)* from 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 CFR 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 any alcohol or drug abuse patient.

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL

FOR OFFICE USE ONLY

Information Requested:

By: **Title:**

Date:

Response(s):

Initials: