RECIPROCAL AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

1. **Identifier:** *Name of person whose information/records will be released.*
   Name: _____(please print)
   Date of Birth: _____ Gender: _____
   SSN: _____ Best way to contact: _____
2. **Entities Authorized to Share Information:**
   Authorizes that information may be released BY each, any and all of the following TO each, any and all of the following, limited to the purpose, need, type and duration identified below. To be able to exchange information, the agency must be marked.

   ____AMOS – Circles of Support – *should we list the address and phone number?*
   ____ATTIC Correctional Services
   ____Catholic Charities
   ____Coulee Cap
   ____Coulee Council on Addictions
   ____Coulee Youth Services
   ____La Crosse County Chemical Health and Justice Sanctions
   ____La Crosse County Economic Support
   ____La Crosse County Jail Chaplain
   ____La Crosse County Mental Health Recovery Services
   ____La Crosse County Sheriff's Department
   ____Legal Action
   ____New Horizons
   ____Western Technical College
   ____Wisconsin Department of Corrections
   ____Workforce Connections
   ____YWCA of the Coulee Region
   ____Healthcare providers
   ____Franciscan Skemp
   ____Gundersen Lutheran
   ____Health Professionals
   ____St. Clare Health Mission
   ____Other, specify: _____
   ____Other, specify: _____

3. **Purpose of Need for Use/Disclosure**
   To facilitate access to and/or coordination of needed services.
4. **Specific Description (Type) of Information/Records Authorized for Release**

In accordance with the conditions listed in this form, I agree to the communication/release of any and all of the information/records identified below (*please put initials by all that your authorize),* limited to information/records that will assist access to and/or coordination of services.

____Health Care	____Social Services	____Mental Health
____Alcohol/Drug	____Housing	____Developmental Disabilities
____Educational	____Vocational	____Financial

5. **Duration** This authorization will remain in effect for the following time period (please check one):

____Expiration in one year from date below. ____Specific expiration date (mm/dd/yy)_____
____Expires after the following action takes place: _____

6. **Signature:** _____
7. **Date:** _____

If signed b y person other than individual state relationship: _____
& Legal Authorization: ____Guardian of the Person ____Parent of Minor

8. **Witness:** _____ Agency: _____

ADDITIONAL INFORMATION REGARDING USE AND DISCLOSURE OF PROTECTED INFORMATION

The providers listed on this authorization recognize your right to confidentiality of protected health care, mental health, and/or substance abuse treatment information as provided under federal and state laws.

Please be aware of the following guidelines:

Federal HIPAA Privacy Rules, State Health/Substance Abuse confidentiality Statutes & Federal Substance Abuse Laws. There are situation where you protection information may be used or disclosed without your authorization and these situations will be explained to you upon request. Please contact your provider (health care, mental health and/or substance abuse), should you have questions about these rules/laws.

No obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, you may not be denied services because you refuse to sign.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. Please contact any of the entities listed on the release and they will assist you. However, your written revocation will not affect any disclosures of your health and related information that the listed providers have already made, in reliance on this authorization, before the time you revoke it.

Re-release. If the entities authorized by this form to disclose and/or receive your information/records are not subject to federal health privacy laws (for example they are entities that do not provide health care, mental health or substance abuse treatment services), information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your information without your prior permission.

Right to Inspect. In authorizing a release of your health care, mental health or substance abuse records, you have the right to inspect (delete or) and have a copy of the material you have given authorization to release, with certain exceptions provided under state and federal law. Should you wish to do this, please contact the relevant entity for further information.

Signatures. If you are 18 years of age or older, you are the only person who is permitted to sign this form to authorize the use or disclosure of your health, mental health and/or substance abuse treatment record, unless you have a legal guardian. If you are under the age of 18, your parent (or legal guardian) has the right to sign this form for you. However, there are situations under state law where you, as a

minor, are either permitted or required to consent to the release of information by signing this form in lieu of a parent or guardian. For more information regarding who is authorized to sign this form, please contact any of the entities listed on the release and they will assist you.