Outagamie County Est. 1851

HEALTH AND HUMAN SERVICES
CHILDREN, YOUTH AND FAMILIES
320 S WALNUT ST, APPLETON WISCONSIN 54911
TELEPHONE 920.832.5161 FAX 920.832.5180

Outagamie County Family Recovery Court (FRC)

Mission: To support the recovery of parent(s) from substance use disorder, to strengthen the overall functioning of the family, and to improve safety, well-being, and permanence for children and their families.

Vision: A community with strong, stable, and resilient families.

Who is Eligible for FRC?

Eligibility Criteria

- Be 18 years of age or older
- Parent or guardian of child with CHIPS filing with substance abuse identified as a safety concern
- Be a resident of Outagamie County, unless approved by the Family Recovery Court Team
- Be clinically screened (e.g., ASAM) or diagnosed with a Substance Use Disorder – Moderate or Severe, identified as appropriate for at least an intensive outpatient level, and willing to participate in the recommended level of care
- Voluntarily agrees to participate in the FRC, as outlined in the FRC Contract and program manual

Disqualifying Criteria

- Individuals meeting violent offender criteria, as outlined in the OJJDP grant
- Child sexual abuse identified as a safety concern in current CHIPS petition/filing

Disqualifying Considerations (additional information may need to be collected)

- A prescription for addictive medications (e.g., narcotics, benzodiazepines) which they intend to continue using on a long-term basis
- Pending felony charge that could interfere with participation in FRC (e.g., long prison or jail sentence is likely to impact participation)
- Registered sex offender, prior conviction of a sex offense, or pending charges or allegations of a sex offense
- Currently enrolled in any other treatment court in Outagamie County (a transfer to FRC will be considered on a case-by-case basis)

Per Standard #4 of the Best Practice Standards, Outagamie County FRC strives to make eligibility determinations based on objective criteria, and refrain from determining eligibility through subjective impressions of the individual's motivation for change and treatment, prior child welfare permanency decisions, or CHIPS court dispositions.

Outagamie County Family Recovery Court (FRC) Referral Checklist

Forms to be turned in with your referral:

☐ **Outagamie County Family Recovery Court Referral Form** – Please fill out ALL sections of this form to the best of your ability. Be sure to have the applicant sign the form.

☐ **Outagamie County/Wisconsin Department of Justice Release** – Please have the potential participant complete the top section of the release and sign and date the second page.

☐ **Waiver of Ex Parte Contact** – Please review this form with the potential participant, and have the potential participant and witness sign on the first page.

☐ **Consent to Release SUD Records For Use in Court System**

☐ **Outagamie County Family Recovery Court Release for FRC** – Please have the potential participant review and complete the top section of the release, initial the checked boxes on the first page, and sign and date the second page.

☐ **Outagamie County Family Recovery Court Release for CHIPS Attorney** – Please have the potential participant review and complete the top section of the release, initial the checked boxes on the first page, and sign and date the second page.

☐ **Outagamie County Family Recovery Court Release for Criminal Justice Treatment Services (CJTS)** – Please have the potential participant review and complete the top section of the release, initial the checked boxes on the first page, and sign and date the second page.

****Referrals take at least 2 weeks to process. If an application is submitted, and the court date is less than 2 weeks away, the application will likely not be processed prior to the court day.**

Referrals will not be considered until the above documentation has been received. Please send the above information to the Family Recovery Court (FRC) Coordinator via mail, fax or encrypted email:

Dawn Schultz
FRC Coordinator
320 South Walnut Street
Appleton, WI 54911
Fax: 920-832-5180
Phone: 920-832-5214
Email: HHSCYFFamilyCourt@outagamie.org

For your Information:

Participation Criteria: This form outlines the eligibility requirements for FRC, please note that meeting eligibility requirements does not guarantee admission into FRC; it is the discretion of the FRC team.

After all of the relevant forms have been sent to the FRC Coordinator, the Coordinator will screen the referral and invite the referral source and any relevant parties to staff the referral with the FRC team. Please contact the FRC Coordinator with any questions.

Outagamie County Family Recovery Court
Referral Form

REFERRING PARTY INFORMATION:		
NAME:	DATE:	CONTACT NUMBER:
TITLE OR RELATIONSHIP TO INDIVIDUAL BEING REFERRED:		

REFERRAL INFORMATION:		
NAME: ☐ M ☐ F		DOB:
ADDRESS: COUNTY:	PHONE:	ATTORNEY:
HAS THE PARENT EVER BEEN CONVICTED OF A VIOLENT OFFENSE? ☐ NO ☐ YES IF YES, LIST CASE # IF KNOWN:		
RACE: (*check all that apply*) ☐ African American ☐ Asian/Pacific Islander ☐ Caucasian ☐ Native American ☐ Hispanic ☐ Other ETHINICITY: ☐ Hispanic ☐ Non-Hispanic		

CHILD'S NAME & CHIPS #	DOB	RACE (*check all that apply*)	ETHINICITY	GAL/ATTORNEY
1. ☐ M ☐ F		☐ African American ☐ Asian/Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other	☐ Hispanic ☐ Non-Hispanic	
2. ☐ M ☐ F		☐ African American ☐ Asian/Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other	☐ Hispanic ☐ Non-Hispanic	
3. ☐ M ☐ F		☐ African American ☐ Asian/Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other	☐ Hispanic ☐ Non-Hispanic	
4. ☐ M ☐ F		☐ African American ☐ Asian/Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other	☐ Hispanic ☐ Non-Hispanic	

IS SUBSTANCE USE A FACTOR IN YOUR ASSESSMENT FOR THIS FAMILY? ☐ NO ☐ YES

WHEN ARE THE NEXT COURT HEARINGS (DATE, TIME, CASE #, HEARING TYPE):

By signing this application, I allow Outagamie County Family Recovery Court team to discuss my eligibility and screening factors with the individual assisting me in applying for Family Recovery Court.

Applicant Signature: **Date:**

Please give completed referral to Dawn Schultz, FRC Coordinator via in person, fax 920-832-5180, or encrypted email HHSCYFFamilyCourt@outagamie.org

Consent for the Release and Exchange of Information with the Wisconsin Department of Justice

Participant Information:

Full Name: _____Date of Birth: _____

Between:

Outagamie County HHS Children, Youth and Families 320 S. Walnut St., Appleton, WI 54911	**AND**	Wisconsin Department of Justice (DOJ) Division of Law Enforcement Services

Purpose of the disclosure: The information collected will be used to support program monitoring, evaluation, and statistical analysis.

Information requesting to be released/disclosed/exchanged:

X Criminal/legal background (including adult and juvenile arrests, charges, convictions, etc.)	X Mental/behavioral health treatment/history
X Dates (Date of birth, date of death, date of treatment and other services, etc.)	X Personally identifiable information (Name Social Security Number, State Identification Number, etc.)
X Drug screen/test results	X Program involvement/progress/discharge
X Education information	X Substance use assessment/diagnosis
X Employment information	X Substance use treatment/history
X Medical information	Other:
X Medications (prescribed)	Other:
X Mental/behavioral health evaluation/ diagnosis	Other:

Disclosure of this confidential information may be made only as necessary for, and pertinent to, my participation in this program. I understand that my alcohol and/or drug treatment records and mental health records are protected under both Wisconsin state statutes and the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Recipients of the information may re-disclose such information only in connection with their official duties. I understand that I may revoke this consent, verbally or in writing, at any time except to the extent that action has been taken in reliance on it.

This consent is effective on the date signed below and ends 6 months after the date of my discharge from the program.

In signing this form, I am granting permission for these agencies to release, disclose, and exchange information outlined above that will be collected during the course of my participation in the program. To the extent allowed by law, information obtained during my participation in the program may continue to be accessed and disclosed for purposes of program monitoring, evaluation, and statistical analysis after expiration of this consent. No information produced as part of evaluating the program will be identifiable to me.

I understand that I am under no obligation to sign this form and that the organizations listed above whom I am authorizing to use and/or disclose my information may not condition my treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this form. However, participation in the program is conditioned upon signing the consent form. I understand I will no longer be eligible for the program if I either do not sign the consent or revoke the consent.

I understand I have the right to inspect or copy the health information I have authorized to be disclosed by this consent form. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under the Wisconsin Department of Health Services Administrative Code (DHS 92.05 and 92.06).

I understand that I will be provided a copy of the signed form, if I request one.

I understand the information that may be disclosed or exchanged may be only used by the above agencies for authorized governmental activities associated with my participation in the program. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy standards.

I hereby authorize the disclosure and exchange of the information described above.

Participant Name (printed)	Participant Signature	Date

Witness Name (printed)	Witness Signature	Date

WAIVER OF EX PARTE CONTACT
WITH TREATMENT COURT JUDGE(S)

I understand that prior to my acceptance into a treatment court program, a team of professionals, including the presiding treatment court judge(s), will meet to discuss my case and determine if I am appropriate for participation.

I am making a decision to permit that contact and allow communications between the treatment court team and the Judge without myself or my attorney present.

Further, if I am accepted into a treatment court program, the treatment court team, including the judge(s), will meet to discuss my progress. Decisions regarding programming and other recommendations will arise out of these discussions. I understand that these discussions will occur without either myself or an attorney representing me present.

_____ _____

Participant Signature Date

_____ _____

Witness Signature Date

HEALTH AND HUMAN SERVICES
OUTAGAMIE COUNTY GOVERNMENT CENTER LEVEL 3
320 S. WALNUT ST. APPLETON, WISCONSIN 54911
TELEPHONE 920.832.4741 Fax 920.832.5164

Consent to Release SUD Records For Use in Court System

I, _____, authorize all county and private providers of substance use disorder (SUD) services to disclose to the Court and following persons or agencies:

- The Outagamie County Family Recovery Court team
- My defense attorney
- The District Attorney's Office; and
- The Guardian ad Litem

All current and prior information obtained during the course of my participation in SUD services that is necessary to monitor my participation in, and compliance with, treatment including assessments, treatment plans, treatment status (admission, participation, cooperation, progress, completion, termination) and drug testing information.

The purpose of this exchange is to inform the Court(s) and the above-named persons and agencies of my eligibility for, enrollment in, attendance at, and progress in SUD treatment.[1]

I understand that my SUD records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise allowed by the federal regulations.

I understand that while these hearings are not open to the public, at times there may be observers present. I specifically consent to this potential disclosure to third persons.

I understand I can revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically upon closure of my juvenile court case(s).

I understand that I may be denied participation in the Family Recovery Court if I refuse to consent to the disclosure described above. I understand that if I revoke my consent prior to the closure of my case I may be immediately terminated from the Family Recovery Court.

I have been provided a copy of this form. I have had the benefit of legal counsel or have voluntarily waived my right to an attorney. I am not under the influence of drugs or alcohol. I fully understand my rights and I am signing this consent voluntarily.

_____ _____
Participant Signature Date

_____ _____
Family Recovery Court Representative Date

I hereby revoke this authorization for disclosure.

_____ _____
Participant Signature Date

_____ _____
Family Recovery Court Representative Date

[1] 42 C.F.R. § 2.35

Outagamie County Department of Health and Human Services
Authorization for Release and Exchange of Health or Confidential Information

1. Individual Served Information (subject of the record)

Individual Served Name _____ Date of Birth _____

Street Address/City, State, Zip _____ Phone Number _____

2. Authorize Outagamie County Department of Health and Human Services, 320 S. Walnut Street, Appleton, WI 54911 to release and receive records TO/FROM (select appropriate division):

☐ **Aging and Long Term Support (ALTS)** ☐ **Children, Youth, and Families (CYF)** ☐ **Economic Support (ES)**

☐ **Mental Health/AODA (MH)** ☐ **Public Health (PH)** ☐ **Youth and Family Services (YFS)**

3. ☐ **Release and receive records TO/FROM:**

Outagamie County Family Recovery Court Team	320 S Walnut Street, Appleton, WI 54911	920.832.5161/920.832.5180
Name of person/Health Care Provider/Agency/Attorney	Street Address/ City, State, Zip Code	Phone/Fax Number

OR

☐ **Verbal release/exchange with (does not apply to SUD)**

Send completed form to: _____
Print Name/Division

I authorize the above named agencies/individuals to communicate and exchange written and/or verbal information, if applicable. I release the above named agencies/individuals from all legal responsibilities that may arise from this act. A uniform charge for reproduction will be assessed. I understand that sub-units of the department, which are subject to HIPAA, may exchange confidential information about individual served and with any providers who have a services contract with the department if such information is necessary to enable an employee or service provider to do his or her job, or to enable the department to coordinate services for the individual served.

4. INFORMATION TO BE RELEASED (individual served initial on line)

x Diagnosis	x Psychological Evaluations	x Child Abuse/Neglect Reports
x Treatment Care Plan	____ Guardianship Records	x Intake/Initial Assessment
x Discharge report	x Progress Notes/Case Notes	____ Financial Information
x Discuss Case Specifics	x Residential Records	____ History and Physical
____ Education Records	____ Vocational Records	____ 504/IEP/IBP
____ Immunizations	____ X-Ray/Ultrasound Report	____ Test Results
x Law Enforcement Records	x Court Records	x Laboratory Results
____ Pick up medications	x Make/Check on appointments	

x Other (Specify): Specify any information needed to coordinate service

In compliance with Federal and Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records including records received from other sources, pertaining to:

x Mental Health/Behavioral	____ Developmental Disabilities
____ Sexually Transmitted Diseases	____ HIV/AIDS
x Intoxicated Driver Assessment/Plan	x Substance Use Disorder Assessment
x Substance Use Disorder Progress Notes	x Substance Use Disorder Treatment Plans
x Substance Use Disorder Discharge Summary	x Substance Use Disorder – Test Results

____ Other (Specify): _____

x Initial here to authorize the agency listed above (#2) to provide to the District Attorney's Office SUD records including records received from other sources to disseminate to counsel of record for purpose of discovery per Wisconsin statute 48.293.

5. Purpose for release: ☐ **Continuity of care** ☐ **Treatment** ☐ **Legal**

☐ **Other (Specify):** Case Management

6. Format of release (subject to applicable fees):

☐ Paper Copy (mail) ☐ Paper Copy (pickup)

☐ Fax ☐ Email (subject to disclosure) Email address Dawn.Schultz@outagamie.org

7. DURING THE TIME PERIOD OF: FROM _____/_____/_____ **TO** _____/_____/_____

8. EXPIRATION DATE: This authorization will expire on: _____/_____/_____ (not to exceed 1 year from date of authorization)

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

- **Your Rights with Respect to 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 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 Privacy Officer at the Department of Health and Human Services, 320 S. Walnut Street, Appleton, Wisconsin, 54911.
  - **Right to Receive Copy of This Authorization.** I understand that if I agree to sign this authorization, which I am not required to do, A signed copy of the form may be available upon request.
  - **Right to Refuse to Sign This Authorization.** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
  - **Right to Withdraw This Authorization.** I understand written notification is necessary to cancel this authorization. See section at bottom of page to withdraw authorization.
- **Disclosure of Direct or Indirect Payment Received by Any Person or Organization Authorized to Use or Disclose my Health Information:** I understand that Outagamie County Department of Health and Human Services will not be receiving any direct or indirect payment in connection with the use or disclosure of my health information.

- **Note to the Patient and Receiving Agency:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you 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.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Individual Served Signature Print Name Date

Parent/Legal Authority Signature (If individual served is a minor) Print Name Date

Individual Served is: ☐ Minor (Under 14) ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Authorized Legal Representative
☐ Legal Guardian ☐ Power of Attorney for Healthcare
☐ Executor of Estate of Deceased

WITHDRAW AUTHORIZATION

I hereby revoke all prior signed consents to the release medical information to any entity, agencies, other providers, family members or legal entity. Even if you received a request that has a copy of my signature, do not release any information.

Individual Served Signature Print Name Date

A PHOTOCOPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL.

Outagamie County Department of Health and Human Services
Authorization for Release and Exchange of Health or Confidential Information

1. Individual Served Information (subject of the record)

Individual Served Name _____ Date of Birth _____

Street Address/City, State, Zip _____ Phone Number _____

2. Authorize Outagamie County Department of Health and Human Services, 320 S. Walnut Street, Appleton, WI 54911 to release and receive records TO/FROM (select appropriate division):

☐ **Aging and Long Term Support (ALTS)** ☑ **Children, Youth, and Families (CYF)** ☐ **Economic Support (ES)**

☐ **Mental Health/AODA (MH)** ☐ **Public Health (PH)** ☐ **Youth and Family Services (YFS)**

3. ☐ **Release and receive records TO/FROM:**

Outagamie County CHIPS Attorney
Name of person/Health Care Provider/Agency/Attorney Street Address/ City, State, Zip Code Phone/Fax Number

OR

☐ **Verbal release/exchange with (does not apply to SUD)**

Send completed form to: _____
Print Name/Division

I authorize the above named agencies/individuals to communicate and exchange written and/or verbal information, if applicable. I release the above named agencies/individuals from all legal responsibilities that may arise from this act. A uniform charge for reproduction will be assessed. I understand that sub-units of the department, which are subject to HIPAA, may exchange confidential information about individual served and with any providers who have a services contract with the department if such information is necessary to enable an employee or service provider to do his or her job, or to enable the department to coordinate services for the individual served.

4. INFORMATION TO BE RELEASED (individual served initial on line)

X Diagnosis	X Psychological Evaluations	X Child Abuse/Neglect Reports
X Treatment Care Plan	X Guardianship Records	X Intake/Initial Assessment
X Discharge report	X Progress Notes/Case Notes	X Financial Information
X Discuss Case Specifics	X Residential Records	____ History and Physical
____ Education Records	X Vocational Records	____ 504/IEP/IBP
____ Immunizations	____ X-Ray/Ultrasound Report	X Test Results
X Law Enforcement Records	X Court Records	X Laboratory Results
____ Pick up medications	X Make/Check on appointments	

X Other (Specify): any information needed to coordinate services

In compliance with Federal and Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records including records received from other sources, pertaining to:

X Mental Health/Behavioral	____ Developmental Disabilities
____ Sexually Transmitted Diseases	____ HIV/AIDS
____ Intoxicated Driver Assessment/Plan	X Substance Use Disorder Assessment
X Substance Use Disorder Progress Notes	X Substance Use Disorder Treatment Plans
X Substance Use Disorder Discharge Summary	X Substance Use Disorder – Test Results

____ Other (Specify): _____

X Initial here to authorize the agency listed above (#2) to provide to the District Attorney's Office SUD records including records received from other sources to disseminate to counsel of record for purpose of discovery per Wisconsin statute 48.293.

5. Purpose for release: ☐ **Continuity of care** ☐ **Treatment** ☐ **Legal**

☐ **Other (Specify):** _____

6. Format of release (subject to applicable fees):

☐ Paper Copy (mail) ☐ Paper Copy (pickup)

☐ Fax ☐ Email (subject to disclosure) Email address_____

7. DURING THE TIME PERIOD OF: FROM _____/_____/_____ **TO** _____/_____/_____

8. EXPIRATION DATE: This authorization will expire on: _____/_____/_____ (not to exceed 1 year from date of authorization)

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

- **Your Rights with Respect to 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 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 Privacy Officer at the Department of Health and Human Services, 320 S. Walnut Street, Appleton, Wisconsin, 54911.
  - **Right to Receive Copy of This Authorization.** I understand that if I agree to sign this authorization, which I am not required to do, A signed copy of the form may be available upon request.
  - **Right to Refuse to Sign This Authorization.** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
  - **Right to Withdraw This Authorization.** I understand written notification is necessary to cancel this authorization. See section at bottom of page to withdraw authorization.
- **Disclosure of Direct or Indirect Payment Received by Any Person or Organization Authorized to Use or Disclose my Health Information:** I understand that Outagamie County Department of Health and Human Services will not be receiving any direct or indirect payment in connection with the use or disclosure of my health information.

- **Note to the Patient and Receiving Agency:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you 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.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Individual Served Signature Print Name Date

Parent/Legal Authority Signature (If individual served is a minor) Print Name Date

Individual Served is: ☐ Minor (Under 14) ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Authorized Legal Representative
☐ Legal Guardian ☐ Power of Attorney for Healthcare
☐ Executor of Estate of Deceased

WITHDRAW AUTHORIZATION

I hereby revoke all prior signed consents to the release medical information to any entity, agencies, other providers, family members or legal entity. Even if you received a request that has a copy of my signature, do not release any information.

Individual Served Signature Print Name Date

A PHOTOCOPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL.

Outagamie County Department of Health and Human Services
Authorization for Release and Exchange of Health or Confidential Information

1. Individual Served Information (subject of the record)

Individual Served Name _____ Date of Birth _____

Street Address/City, State, Zip _____ Phone Number _____

2. Authorize Outagamie County Department of Health and Human Services, 320 S. Walnut Street, Appleton, WI 54911 to release and receive records TO/FROM (select appropriate division):

☐ **Aging and Long Term Support (ALTS)** ☐ **Children, Youth, and Families (CYF)** ☐ **Economic Support (ES)**

☐ **Mental Health/AODA (MH)** ☐ **Public Health (PH)** ☐ **Youth and Family Services (YFS)**

3. ☐ **Release and receive records TO/FROM:**

Criminal Justice Treatment Services	320 S Walnut Street, Appleton, WI 54911	920.832.5160 Phone
Name of person/Health Care Provider/Agency/Attorney	Street Address/ City, State, Zip Code	Phone/Fax Number

OR

☐ **Verbal release/exchange with (does not apply to SUD)**

Send completed form to: _____
Print Name/Division

I authorize the above named agencies/individuals to communicate and exchange written and/or verbal information, if applicable. I release the above named agencies/individuals from all legal responsibilities that may arise from this act. A uniform charge for reproduction will be assessed. I understand that sub-units of the department, which are subject to HIPAA, may exchange confidential information about individual served and with any providers who have a services contract with the department if such information is necessary to enable an employee or service provider to do his or her job, or to enable the department to coordinate services for the individual served.

4. INFORMATION TO BE RELEASED (individual served initial on line)

____ Diagnosis	____ Psychological Evaluations	____ Child Abuse/Neglect Reports
____ Treatment Care Plan	____ Guardianship Records	____ Intake/Initial Assessment
____ Discharge report	____ Progress Notes/Case Notes	____ Financial Information
____ Discuss Case Specifics	____ Residential Records	____ History and Physical
____ Education Records	____ Vocational Records	____ 504/IEP/IBP
____ Immunizations	____ X-Ray/Ultrasound Report	____ Test Results
____ Law Enforcement Records	____ Court Records	____ Laboratory Results
____ Pick up medications	____ Make/Check on appointments	

X Other (Specify): Eligibility for Outagamie County Treatment Court

In compliance with Federal and Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records including records received from other sources, pertaining to:

____ Mental Health/Behavioral	____ Developmental Disabilities
____ Sexually Transmitted Diseases	____ HIV/AIDS
____ Intoxicated Driver Assessment/Plan	X Substance Use Disorder Assessment
X Substance Use Disorder Progress Notes	X Substance Use Disorder Treatment Plans
____ Substance Use Disorder Discharge Summary	____ Substance Use Disorder – Test Results

____ Other (Specify): Eligibility for Outagamie County Treatment Court

X Initial here to authorize the agency listed above (#2) to provide to the District Attorney's Office SUD records including records received from other sources to disseminate to counsel of record for purpose of discovery per Wisconsin statute 48.293.

5. Purpose for release: ☐ **Continuity of care** ☐ **Treatment** ☐ **Legal**

☐ **Other (Specify):** _____

6. Format of release (subject to applicable fees):

☐ Paper Copy (mail) ☐ Paper Copy (pickup)

☐ Fax ☐ Email (subject to disclosure) Email address_____

7. DURING THE TIME PERIOD OF: FROM _____/_____/_____ **TO** _____/_____/_____

8. EXPIRATION DATE: This authorization will expire on: _____/_____/_____ (not to exceed 1 year from date of authorization)

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

- **Your Rights with Respect to 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 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 Privacy Officer at the Department of Health and Human Services, 320 S. Walnut Street, Appleton, Wisconsin, 54911.
  - **Right to Receive Copy of This Authorization.** I understand that if I agree to sign this authorization, which I am not required to do, A signed copy of the form may be available upon request.
  - **Right to Refuse to Sign This Authorization.** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
  - **Right to Withdraw This Authorization.** I understand written notification is necessary to cancel this authorization. See section at bottom of page to withdraw authorization.
- **Disclosure of Direct or Indirect Payment Received by Any Person or Organization Authorized to Use or Disclose my Health Information:** I understand that Outagamie County Department of Health and Human Services will not be receiving any direct or indirect payment in connection with the use or disclosure of my health information.

- **Note to the Patient and Receiving Agency:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you 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.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Individual Served Signature	Print Name	Date
Parent/Legal Authority Signature (If individual served is a minor)	Print Name	Date

Individual Served is: ☐ Minor (Under 14) ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Authorized Legal Representative
☐ Legal Guardian ☐ Power of Attorney for Healthcare
☐ Executor of Estate of Deceased

WITHDRAW AUTHORIZATION

I hereby revoke all prior signed consents to the release medical information to any entity, agencies, other providers, family members or legal entity. Even if you received a request that has a copy of my signature, do not release any information.

Individual Served Signature	Print Name	Date

A PHOTOCOPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL.