A program of Catholic Charities

Authorization for Use/Disclosure of Confidential Information

5 Door Recovery
810 W. Olin Avenue, Madison, WI 53715, Phone (608) 827-9170, Fax (608) 630-9078

Client Information:

______________________________/______________________/________________ ________________

Last Name First Name MI Date of Birth

____/ ____________________/ _________/____________

Street Address City State Zip Code

I Authorize:	**To Release Confidential Information To:**
5 Door Recovery	Dane County Human Services
Name of Person/Organization	Name of Person/Organization
810 W. Olin Ave	1202 Northport Dr
Street Address	Street Address
Madison / WI / 53715	Madison / WI / 53704
City / State / Zip Code	City / State / Zip Code

Information to be Released: (check one)

☐ Oral only ☐ Written Only ☒ Oral and Written Communication

Release only the specific information checked:

- ☒ Laboratory Results
- ☒ Psychiatric Evaluation
- ☒ Treatment Discharge Summary
- ☒ Psychological Evaluation
- ☒ Bio-Psycho-Social History
- ☒ Progress Notes
- ☒ Medical History & Exam
- ☒ Treatment Plan
- ☒ AODA Assessment /Evaluation
- ☒ Aftercare Plan
- ☐ Other, Specify: ____

Reason for Disclosure of Confidential Information:

Coordination of services, room & board funding

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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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Authorization for Use/Disclosure
of Confidential Information

Expiration Date: This Authorization is valid until __________________________________ (No longer than 12 months).

Your Rights Pertaining to the Authorization:

Right to inspect or copy information Authorized: I understand that I have the right to inspect or copy the confidential information to be released under this Authorization, subject to certain exceptions provided by State and Federal law. Contact the Program Director of you would like to do so.

Right to receive a copy of this Authorization: I understand that if I sign this Authorization, which I am not required to do, that I must receive a signed copy of this Authorization.

Right to refuse to sign this Authorization: I understand that I am under no obligation to sign this Authorization. Treatment, payment, enrollment in a service or eligibility for a service cannot be conditioned upon obtaining this Authorization.

Right to revoke this Authorization: I understand written notification is necessary to revoke this Authorization. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I may contact Catholic Charities at the phone number above. I am aware that my revocation will not be effective as to uses and disclosures of confidential information that the person(s) and or organization(s) named above have already made in reliance of this signed Authorization.

I have reviewed the Authorization. I understand the information presented in this Authorization and by signing this Authorization, I am confirming my approval for release of confidential information.

Signature of Client: ____ Date: __________________________

Signature of Guardian or Power of Attorney (if applicable):

____ Date: __________________________

If signed by other than the client, indicate relationship to client and legal authority for signature:

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