family service
counseling • support • compassion

Family Service
Center for the Prevention of Family Violence
Authorization to Release & Obtain Confidential Information

I, the undersigned, hereby authorize the disclosure of the records and information specified below concerning:

_____ whose date of birth is _____
(Print Your Name)
by **Family Service** to: (Please use a separate release form for each authorization.)

☐ **Department of Probation and Parole – indicate the county:** _____

_____
(Print Probation Officer's Name)

☐ **District Attorney's Office – indicate the county:** _____

_____
(Print District Attorney's Name)

☐ **Waukesha Community Services, Inc.**

☐ **Waukesha County Department of Health and Human Services**

☐ **Other** _____

The types of information to be released: ☒ **Verbal** ☒ **Written**

The type of information to be released:

☐ Intake/Initial Assessment ☐ Staffing and Progress Notes ☐ Social History ☐ Discharge Summary

☐ Treatment Plan / Reviews ☒ Group Attendance/Participation Roster ☐ Other (please specify)_____

Purpose for Need of Disclosure:

☐ Personal ☒ Continuity and Coordination of Care ☐ Legal Investigation

I understand that if the person and/or agency listed above are not governed by applicable federal and state laws and administrative codes, the confidential information disclosed as a result of this signed authorization, may no longer be protected from the further re-disclosure without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that I have the right to inspect or have a copy of the confidential information that I have authorized to be disclosed by this signed authorization form. I understand that if I agree to sign this authorization, which I am not required to sign; I must be provided with a signed copy of the form. I understand that I am not under any obligation to sign this form and that the person and/or agency listed above who I am authorizing to use and/or disclose my confidential information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefit, on my decision to sign this authorization. I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization, I may contact Family Service of Waukesha staff providing and/or coordinating my services. I am aware that my withdrawal will not be effective as to the uses and/or disclosures of my health information that the person and/or agency listed has already contacted in reference to this authorization prior to its cancellation.

Expiration Date: this authorization expires 90 days following the completion of active services with Family Service unless a specific date is entered here _____ or of revocation is submitted.

Print Name _____

Signature: _____ Date: _____

Signature is that of ☐ Client / Patient ☐ Parent of Minor ☐ Legal Guardian ☐ Client / Patient's Representative

Signature of Witness: _____ Date: _____

Revised 10/25/17