

CONFIDENTIAL INFORMATION AA RELEASE AUTHORIZATION (10/2014)

Completion of this form authorizes the release of information described in the section below called "Specific Description of Records Authorized for Release." The person (record subject) whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication/somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances. Section 51.30, Wis. Stats., DHS 92.03-92.06 Wis. Adm. Code.

Name – Person Whose Records Will be Released (Record Subject)	
Address	
City, State, Zip Code	
Identifying Number (If Any)	Date of Birth
Name - Information May be Released To Katie Beckett Program/CompassWisconsin: Threshold	
Organization Division of Long Term Care	
Address P.O. Box 7851, Room 418	
City, State, Zip Code Madison WI 53707-7851	

Name and Address – Agency / Organization I Authorize to Release Information

Specific Description of Records Authorized for Release (Include dates of records, if applicable)

MEDICAL RECORDS

- Medical History
- Discharge Summaries
- Plan of Care
- HIV Test Results / AIDS Treatment Records
- Progress / Clinical Notes
- Other – Specify:

THERAPY EVALUATIONS / UPDATES

- Occupational Therapy
- Physical Therapy
- Speech Language Pathology
- Psychotherapy
- In-home Autism Therapy
- Other – Specify:

EARLY INTERVENTION OR SCHOOL RECORDS

- IEP Evaluation Report
- Early Intervention Report
- Current IEP
- Current IFSP
- Other – Specify:

MENTAL HEALTH RECORDS

- All Mental Health Records
- Other – Specify:

Purpose or Need for Release of Information (Be Specific)

These records will be used to determine your child's level of care as required by Federal and State Medicaid standards. This use usually includes the review of the information by Wisconsin Katie Beckett Program/CompassWisconsin: Threshold staff in processing your application for benefits. In some cases your information may be viewed by staff who process appeals of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related civil or criminal proceedings.

Understandings

- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:
 - No exceptions
 - Exceptions (specify): **Failing to sign this release, or revoking the release before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits.**
- The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.
- I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release information.
- This authorization also permits the release of records generated on or after the date of my signature.
- Unless revoked, this authorization will remain in effect until the expiration time indicated below.

Choose One:

- Authorization expires as of _____ (Date).
- Authorization expires **12** month(s) from the date I sign this authorization.
- Authorization expires after the following action takes place:

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

SIGNATURE – Child (If age 14 years or older)	<input type="checkbox"/> Check here if your child is unable to sign	Date Signed
SIGNATURE - Other Person Legally Authorized to Consent to Disclosure	Title or Relationship to Record Subject	Date Signed