If you are referring a youth for therapy who is not living with their legal guardian, the following attached forms must be fully completed by a legal guardian before the youth will be added to the waiting list:

1. Consent for Mental Health –
   i. Signature of Legal Guardian and date
   ii. Relationship to patient
   iii. Witness signature, time, and date

2. Information for Clients –
   i. Page 3 of 3 must be signed and dated by legal guardian and returned to us (you can make a copy for the parent to keep)

3. Authorization for Release of Information for the following people (a&b are required):
   a. Required: Out of home care provider (foster parent, group home, or other identified supportive adult who will be receiving services with the target youth)
   b. Required: Family Case Manager or Family Support Worker (if parent refuses to sign for one reason or another please let us know)
   c. Optional: Previous therapist; School; Medication Prescriber- these forms are optional, but helpful up front and may be requested at a later date
   d. When completing each Release of Information, the following must be on each form:
      i. Full name and address of the person or entity we are exchanging information with
      ii. Legal guardian’s initials by the 9 starred lines in the middle of the form allowing the therapist to share the necessary information throughout treatment.
      iii. Legal guardian’s signature and date at the bottom of the form
      iv. Legal guardian specifies their relationship to the child at the bottom of form.
      v. Witness signature and date at the bottom of the form

Once these forms are completed in their entirety please email them to our office at ICFWTherapy@chw.org to begin the phone screening process to determine eligibility for our programming.
No Show and Late Cancel Policy

It is important to attend all scheduled sessions with your therapist. This helps your child do well in treatment.

To give your child the best care, we have a policy for no show and late cancel visits.

A no-show is when you:
- do not show for a scheduled visit
- call to cancel after the visit time
- cancel within 1 hour of your scheduled appointment time

A late cancel is when you:
- Cancel a visit in less than 24 hours before your child’s appointment.
- When you come late and half of your appointment is already over. This means 20 minutes late for a Therapy appointment.

If you have 3 no-shows and/or late cancels within a 1 year time from your first missed or late canceled visit with your child’s therapist, you may not be able to schedule more visits with that or other therapists.
Consent for Mental Health Care

- Please read this form.
- Ask questions about anything you do not understand before you sign this form.
- When you sign it, you are giving us permission to treat you or your child.

I understand and agree that taking part in mental health care at Children's Hospital of Wisconsin (CHW) is my choice.

To help me understand the care, I will get information about the following:
- The type of mental health care I/my child will get in this clinic
- Recommendations and benefits of care, as well as possible results and side effects
- How long care may last and desired outcomes recommended in my treatment plan
- My rights and responsibilities in this clinic. This includes my participation in care and the development and on-going review of my treatment plan
- Other choices for care
- How to report a problem. This is called a grievance procedure

I have been offered a "Clients Rights and the Grievance Procedure for Community Services" brochure.

Fees are based on the length and type of care. I am responsible for any amount not paid by insurance. Co-payments and deductibles are not paid by insurance. I may ask for a list of fees at any time.

Information from each visit is kept in your/your child's CHW medical record. My/my child's mental health records may be shared with health providers, insurance companies and Children's Hospital and Health System for treatment, payment and health care operations.

I understand that care will be finished in the clinic and I will be discharged if:
- Treatment is finished or I ask to stop care.
- I miss visits, do not call the provider, or fail to return a call after missing a lot of care.
- I am referred to another agency for different care.
- I do not follow the recommended care or cause problems in the clinic that are disruptive.

I have the right to remove my consent for mental health care at any time. I need to make this request in writing. This consent lasts for 15 months from the date of signature.

I have read this information. I am legally able to consent for my child.

Signature: X __________________________ Date: ________ Relationship to patient: ________________

Signature of patient/client age 14 years and older: X __________________________ Date: ________

Signature of witness: X __________________________ Date: ________ Time (Required): ________
Welcome to the Institute for Child and Family Well-Being at Children's Hospital of Wisconsin. You are in good care here.

Children's Hospital of Wisconsin – Community Services (CHW-CS, formerly CSSW) is a private, not-for-profit child welfare agency providing counseling and other mental health services through Child & Family Well-Being. A goal of Child & Family Well-Being is to strengthen families and promote child well-being through holistic, trauma-informed care. This sheet contains important information about your/your child's care with us. Please read it carefully. Talk to your provider about any questions you may have. A provider is a therapist, psychiatrist, or psychologist who is helping you/your child with your/your child's mental health care.

Eligibility
Children and adolescents ages 0-18 and their families are eligible for care. No one will be denied services because of an inability to pay. If there is any reason why we are not the best place to care for you, we will explain why and help you find care elsewhere.

Hours
Clinic hours are Monday through Friday 8:00 a.m. to 5:00 p.m. by appointment. Evening and weekend hours may be available by appointment.

Length of Care
Services may continue as long as you attend your scheduled visits and until you meet your treatment goals.

Ending Care
You and your provider will decide when you have met your goals and no longer need regular care. This is when you have successfully completed treatment. Congratulations! There are some reasons why your care may stop before you have successfully completed treatment. These are listed on the Consent for Mental Health Care of which you signed and received a copy at check-in.

Cancellations/Attendance Policy
It is important to come to all of your scheduled therapy visits. This helps you to do well in your care.
To give you the best care, we have a policy for no-show and late cancel visits.
A no-show is when you:
- do not show for a scheduled visit
- call to cancel after the visit time
A late cancel is when you:
- Cancel a visit less than 24 hours before your appointment.
- Arrive when more than ½ of your appointment time has passed.

If you have 3 no-shows and/or late cancels within a 1 year time from your first visit with your provider, you may not be able to schedule more visits with that or other providers.
INFORMATION FOR CLIENTS

When you are not able to make a visit, call your provider as soon as you can.

Emergencies
In the event of a life-threatening emergency, call 911.

If you have a non-life threatening emergency that occurs during business hours, you may call your child’s provider. If they are not available, you may be connected with another therapist or the clinic manager. If you call during non-business hours, you will be directed to an answering service to assist you.

Suicide Prevention/Resources
Here are some suicide prevention resources for you. Talk to your provider if you have questions or concerns, or would like more local resources. Call 911 if you are having a life-threatening emergency.

211 Impact – First Call for Help
Provides 24-hour mental health crisis intervention, information, referral and listening support. If using a cell phone, dial (414) 773-0211 or toll free (866) 211-3380. For more information, visit www.impactinc.org. Consejeros que hablan ingles y español están disponibles.

1-800-SUICIDE (784-2433) – National Hopeline Network
Counselors are available 24-hours-a-day, seven-days-a-week. For more information, visit www.HealthyPlace.com. Consejeros que hablan ingles y español están disponibles.

Safety
CHW-CS wants clients to feel safe in all of our clinics. Firearms and weapons are not allowed in any CHW building. If you or anyone with you creates an unsafe environment, we will cancel your visit and may contact law enforcement. We may end your care at this clinic if we can’t keep you, our staff, and our other clients and family members safe.

Treatment Plans
During your first 1 to 2 appointments, you and your provider will develop a treatment plan. This will include a list of your strengths, challenges, and goals for recovery. Your provider may also give you an idea of how long your mental health care might last. The treatment plan is updated by you and your provider every 90 days. This update will track how you are doing with your goals and any new goals or changes to your goals for the next 3 months. A parent’s/legal guardian’s signature is needed each time the treatment plan is updated or changed. Youth 14 and older are also expected to sign the treatment plan. For more information, see the Psychotherapy: Questions and Answers handout.

Complaints and Grievances
It is our goal to provide the best and safest care to you or your child. If you have a complaint, we ask you to discuss it with your provider or the clinic manager.

If you believe your rights have been violated, please call 414-266-7848 or toll free (800) 556-8090 and ask to speak with a Client’s Right's Specialist.
INFORMATION FOR CLIENTS

There will be no consequences for or retaliation against you or anyone assisting you in the filing of a complaint or grievance.

Access to Records
You may request copies of your medical records by calling (414) 266-2301 or fax at (414) 266-6316. The clinic staff, including your provider, is not allowed to give you medical records from the office.

Email and Social Media
For your safety and privacy, your provider is not allowed to respond to your or your parents, guardians, or other family members’ emails, texts, or calls to their personal phones. They may also not accept Facebook “friend” or other social medial requests. If you need to talk to your provider about your care, call the clinic to talk to them or schedule an appointment to see them.

Fee Policy
At Children’s Hospital of Wisconsin-Community Services, we provide the best and safest care regardless of a family’s ability to pay. Financial assistance may be available. CHW’s Financial Assistance Policy and Application form are available at:

- chw.org/financialassistance
- By phone at (414) 266-6262

Your 100% Satisfaction is Our Goal
We value your opinion and want you to be completely satisfied with our mental health services to you. Often funders like the United Way also want to see our client survey results when making funding decisions. If you receive a survey in your mail at home, please take time to share your opinions and feedback so we can continually improve our services to you. You will receive no more than 4 surveys per year.

My signature below indicates that I have reviewed this “Information for Clients” form with my provider and have been offered the following documents:

- Joint Notice of Privacy Practices
- Rights of Children and Adolescents in Outpatient Mental Health Treatment (For clients age 12-17)
- Psychotherapy: Questions and Answers

Signature (adult or minor age 14 or older): __________________________ Date: ____________

Signature of Guardian if signer is under the age of 18: __________________________ Date: ____________

Provider Signature: __________________________ Date: ____________
Children's Hospital of Wisconsin

Kids deserve the best.

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: ___________________________ D.O.B.: __________________

(1) I/We, ___________________________, hereby request & authorize (specify program name) Institute for Child and Family Well-Being of Children's Service Society of Wisconsin d/b/a Children's Hospital of Wisconsin-Community Services to:

☐: Disclose information and records to: (include name & address)

☐: Receive information and records from: (include name & address)

(2) Disclosure of this information is for the purpose of: (select which apply)

☐: Diagnoses, assessment, treatment or provision of services
☐: Legal purposes
☐: Insurance eligibility
☐: Other: (please specify)

(3) This authorization will expire:

☐ One time information sharing

The information provided covers the time period ____________________________

Authorization expires 90 days from date of signature. Date of expiration ____________________________

☐ Ongoing service provisions/continuity of care

The information provided covers the time period ____________________________

Authorization will expire in one (1) year, unless an earlier date is specified. Date of expiration ____________________________

(4) Since a general authorization for the release of medical or other information is not sufficient for all purposes, the following specific information is requested. The specific information to be released from the records is as follows: (select which apply)

[Client must initial each line which applies to request]

ACDA Findings
Physical/Medical Findings
Psychiatric Findings
Education Findings
Social Work Findings
Progress Notes & Findings
Psychological Findings
Recommendations
Other: (specify) ____________________________

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to receive a copy of authorization: You have a right to receive a copy of this authorization.

Right to refuse to sign this authorization: You have the right to refuse to sign this authorization. You understand that this authorization is voluntary and that you may refuse to sign it. Unless allowed by law, your refusal to sign this authorization will not affect your ability to obtain treatment.

Right to withdraw this authorization: You have a right to withdraw this authorization at any time. You must submit written notification of your desire to cancel this authorization. You should be aware that your withdrawal will not be effective until received by Children's Service Society of Wisconsin d/b/a Children's Hospital of Wisconsin-Community Services and will not be effective regarding the use or disclosures made prior to the cancellation.

Right to inspect or receive a copy of the information: You have a right to review and/or receive a copy (at a reasonable fee) of the information you authorized to be used or disclosed by this authorization. (There are certain legal restrictions to this that may be applicable, for example, a minor's records cannot be released to parents who have been denied physical placement of the minor). You may arrange to inspect your file or obtain copies of this information disclosed by contacting Children's Service Society of Wisconsin d/b/a Children's Hospital of Wisconsin-Community Services.

Prohibition on re-disclosure: The information and records being requested are protected under Federal and State confidentiality laws. Such laws prohibit the re-disclosure of such information unless further disclosure is expressly permitted by written consent or as otherwise permitted by law. However, information disclosed may potentially be re-disclosed by the recipient and may no longer be protected by the federal privacy and confidentiality rules.

Client's Signature: ______________________ Date: __________________

AND/OR

Person Authorized to Sign for Client: ______________________ Date: __________________

Specify Relationship to Client: ______________________

Witness: ______________________ Date: __________________

Form of Verification: ☐ Personal knowledge ☐ Identification: (specify form)

Federal Rules (42 CFR Part 2) restrict any use of this information to criminal

*Signature*
Family Case Manager/Support Specialist

Children's Hospital of Wisconsin

Kids deserve the best.

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _______________________________ D.O.B.: _______________________________

(1) I/We, ____________________________, hereby request & authorize (specify program name) __________________________, Institute for Child and Family Well-Being, to disclose information and records to: (include name & address)

(2) Disclosure of this information is for the purpose of: (select which apply)

☒ Diagnostic, assessment, treatment or provision of services
☒ Legal purposes
☒ Insurance eligibility
☐ Other: __________________________

(3) This authorization will expire:

☒ One time information sharing
☐ Ongoing service provisions/continuity of care

Authorization expires 90 days from date of signature. Date of expiration __________________________

OR

Authorization will expire in one (1) year, unless an earlier date is specified. Date of expiration __________________________

(4) Since a general authorization for the release of medical or other information is not sufficient for all purposes, the following specific information is requested. The specific information to be released from the records is as follows: (select which apply)

☒ ACIDA Findings
☒ Education Findings
☒ Psychological Findings

☒ Physical/Medical Findings
☒ Social Work Findings
☒ Recommendations

☒ Psychiatric Findings
☒ Progress Notes & Findings
☒ Other: __________________________

CLIENT MUST INITIAL EACH LINE WHICH APPLIES TO REQUEST

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to receive a copy of authorization: You have a right to receive a copy of this authorization.

Right to refuse to sign this authorization: You have the right to refuse to sign this authorization. You understand that this authorization is voluntary and that you may refuse to sign it. Unless allowed by law, your refusal to sign this authorization will not affect your ability to obtain treatment.

Right to withdraw this authorization: You have a right to withdraw this authorization at any time. You must submit written notification of your desire to cancel this authorization. You should be aware that your withdrawal will not be effective until received by Children’s Service Society of Wisconsin dba Children’s Hospital of Wisconsin - Community Services and will not be effective regarding the uses or disclosures made prior to the cancellation.

Right to inspect or receive a copy of the information: You have a right to review and/or receive a copy (at a reasonable fee) of the information you authorized to be used or disclosed by this authorization. (There are certain legal restrictions to this that may be applicable, for example, a minor’s records cannot be released to parents who have been denied physical placement of the minor). You may arrange to inspect your file or obtain copies of this information disclosed by contacting Children’s Service Society of Wisconsin dba Children’s Hospital of Wisconsin - Community Services.

Prohibition on re-disclosure: The information and records being requested are protected under Federal and State confidentiality laws. Such laws prohibit the re-disclosure of such information unless further disclosure is expressly permitted by written consent or as otherwise permitted by laws. However, information disclosed may potentially be re-disclosed by the recipient and may no longer be protected by the federal privacy and confidentiality rules.

Client’s Signature: __________________________ Date: __________________________

AND/OR

Person Authorized to Sign for Client: __________________________ Date: __________________________

Specify Relationship to Client: __________________________ Date: __________________________

Witness: __________________________ Date: __________________________

Form of Verification: ☐ Personal knowledge ☐ Identification: (specify form)
AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _______________________  D.O.B.: _______________________

(1) I/We, __________________________ hereby request & authorize (specify program name) Institute for Child and Family Well-Being of Children's Service Society of Wisconsin d/b/a Children's Hospital of Wisconsin-Community Services to:

☒: Disclose information and records to: (include name & address)

☒: Receive information and records from: (include name & address)

(2) Disclosure of this information is for the purpose of: (select which apply)

☒: Diagnostic, assessment, treatment or provision of services
☒: Legal purposes
☒: Insurance eligibility
☐: Other: (please specify)

(3) This authorization will expire:

☐: One time information sharing

The information provided covers the time period ___________________

Authorization expires 90 days from date of signature. Date of expiration ___________________

OR

☒: Ongoing service provisions/continuity of care

The information provided covers the time period 1 (one) year

Authorization will expire in one (1) year, unless an earlier date is specified. Date of expiration ___________________

(4) Since a general authorization for the release of medical or other information is not sufficient for all purposes, the following specific information is requested. The specific information to be released from the records is as follows: (select which apply)

(CLIENT MUST INITIAL EACH LINE WHICH APPLIES TO REQUEST)

ACDA Findings
Physical/Medical Findings
Psychiatric Findings

Education Findings
Social Work Findings
Progress Notes & Findings

Psychological Findings
Recommendations
Other: (specify)

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to receive a copy of authorization: You have a right to receive a copy of this authorization.

Right to refuse to sign this authorization: You have the right to refuse to sign this authorization. You understand that this authorization is voluntary and that you may refuse to sign it. Unless allowed by law, your refusal to sign this authorization will not affect your ability to obtain treatment.

Right to withdraw this authorization: You have a right to withdraw this authorization at any time. You must submit written notification of your desire to cancel this authorization. You should be aware that your withdrawal will not be effective until received by Children's Service Society of Wisconsin d/b/a Children's Hospital of Wisconsin-Community Services and will not be effective regarding the uses or disclosures made prior to the cancellation.

Right to inspect or receive a copy of the information: You have a right to inspect and/or receive a copy (at a reasonable fee) of the information you authorized to be used or disclosed by this authorization. (There are certain legal restrictions to this that may be applicable, for example, a minor's records cannot be released to parents who have been denied physical placement of the minor). You may arrange to inspect your file or obtain copies of this information disclosed by contacting Children's Service Society of Wisconsin d/b/a Children's Hospital of Wisconsin-Community Services.

Prohibition on re-disclosure: The information and records being requested are protected under Federal and State confidentiality laws. Such laws prohibit the re-disclosure of such information unless further disclosure is expressly permitted by written consent or as otherwise permitted by law. However, information disclosed may potentially be re-disclosed by the recipient and may no longer be protected by the federal privacy and confidentiality rules.

Client's Signature: _______________________  Date: _______________________

AND/OR

Person Authorized to Sign for Client: _______________________  Date: _______________________

Specify Relationship to Client: _______________________  Date: _______________________

Witness: _______________________  Date: _______________________  Form of Verification: □ Personal knowledge □ Identification: (specify form)
AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: ___________________________ D.O.B.: ___________________________

(1) I/We, ___________________________ hereby request & authorize (specify program name) Institute for Child and Family Well-Being of Children’s Service Society of Wisconsin d/b/a Children’s Hospital of Wisconsin-Community Services to:
\(\text{\checkmark}\) Disclose information and records to: (include name & address)

\(\text{\checkmark}\) Receive information and records from: (include name & address)

(2) Disclosure of this information is for the purpose(s): (select which apply)
\(\text{\checkmark}\) Diagnostics, assessment, treatment or provision of services
\(\text{\checkmark}\) Legal purposes
\(\text{\checkmark}\) Insurance eligibility
\(\square\) Other: (please specify)

(3) This authorization will expire:
\(\text{\checkmark}\) One time information sharing

The information provided covers the time period __________________
Authorization expires 90 days from date of signature. Date of expiration __________________
OR

\(\text{\checkmark}\) Ongoing service provisions/continuity of care

The information provided covers the time period __________________
Authorization will expire in one (1) year, unless an earlier date is specified. Date of expiration __________________

(4) Since a general authorization for the release of medical or other information is not sufficient for all purposes, the following specific information is requested. The specific information to be released from the records is as follows: (select which apply)

\(\text{\checkmark}\) ACDA Findings
\(\text{\checkmark}\) Physical/Medical Findings
\(\text{\checkmark}\) Psychiatric Findings

\(\text{\checkmark}\) Education Findings
\(\text{\checkmark}\) Social Work Findings
\(\text{\checkmark}\) Progress Notes & Findings

\(\text{\checkmark}\) Psychological Findings
\(\text{\checkmark}\) Recommendations

\(\text{\checkmark}\) Other: (specify)

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to receive a copy of authorization: You have a right to receive a copy of this authorization.

Right to refuse to sign this authorization: You have the right to refuse to sign this authorization. You understand that this authorization is voluntary and that you may refuse to sign it. Unless allowed by law, your refusal to sign this authorization will not affect your ability to obtain treatment.

Right to withdraw this authorization: You have a right to withdraw this authorization at any time. You must submit written notification of your desire to cancel this authorization. You should be aware that your withdrawal will not be effective until received by Children’s Service Society of Wisconsin d/b/a Children’s Hospital of Wisconsin-Community Services and will not be effective regarding the uses or disclosures made prior to the cancellation.

Right to inspect or receive a copy of the information: You have a right to review and/or receive a copy (at a reasonable fee) of the information you authorized to be used or disclosed by this authorization. (There are certain legal restrictions to this that may be applicable, for example, a minor’s records cannot be released to parents who have been denied physical placement of the minor). You may arrange to inspect your file or obtain copies of this information disclosed by contacting Children’s Service Society of Wisconsin d/b/a Children’s Hospital of Wisconsin-Community Services.

Prohibition on re-disclosure: The information and records being requested are protected under Federal and State confidentiality laws. Such laws prohibit the re-disclosure of such information unless further disclosure is expressly permitted by written consent or otherwise permitted by laws. However, information disclosed may potentially be re-disclosed by the recipient and may no longer be protected by the federal privacy and confidentiality rules.

Client’s Signature: ___________________________ AND/OR

Date: ___________________________

\(\text{\checkmark}\) Person Authorized to Sign for Client: ___________________________

Date: ___________________________

\(\text{\checkmark}\) Specify Relationship to Client: ___________________________

Date: ___________________________

\(\text{\checkmark}\) Witness: ___________________________

Date: ___________________________

Form of Verification:  \(\square\) Personal knowledge  \(\square\) Identification: (specify form)

Federal Rules (42 CFR Part 2) restrict any use of this information to criminal.
Authorizations for release of information

Client Name: ___________________________ D.O.B.: ___________________________

1. (We) hereby request & authorize (specify program name) Institute for Child and Family Well-Being
   of Children’s Service Society of Wisconsin d/b/a Children’s Hospital of Wisconsin Community Services to:
   ☒ I: Disclose information and records to: (include name & address) __________________________
   ☒ Receive information and records from: (include name & address) __________________________

2. Disclosure of this information is for the purpose of: (select which apply)
   ☒ Diagnoses, assessment, treatment or provision of services ☒ Legal purposes ☒ Insurance eligibility
   ☐ Other: (please specify) __________________________

3. This authorization will expire:
   ☐ One time information sharing
   ☒ Ongoing service provisions/continuity of care
   Authorization expires 90 days from date of signature. Date of expiration __________________________
   OR
   The information provided covers the time period __________________________
   Authorization will expire in one (1) year, unless an earlier date is specified. Date of expiration __________________________

4. Since a general authorization for the release of medical or other information is not sufficient for all purposes, the following
   specific information is requested. The specific information to be released from the records is as follows: (select which apply)
   (CLIENT MUST INITIAL EACH LINE WHICH APPLIES TO REQUEST)
   ☒ AODA Findings ☒ Education Findings ☒ Psychological Findings
   ☒ Physical/Medical Findings ☒ Social Work Findings ☐ Recommendations
   ☒ Psychiatric Findings ☒ Progress Notes & Findings ☐ Other: (specify) __________________________

Your Rights with Respect to this Authorization

Right to receive a copy of authorization: You have a right to receive a copy of this authorization.

Right to refuse to sign this authorization: You have the right to refuse to sign this authorization. You understand that this authorization
   is voluntary and that you may refuse to sign it. Unless allowed by law, your refusal to sign this authorization will not affect your ability
   to obtain treatment.

Right to withdraw this authorization: You have a right to withdraw this authorization at any time. You must submit written notification
   of your desire to cancel this authorization. You should be aware that your withdrawal will not be effective unless received by Children’s
   Service Society of Wisconsin d/b/a Children’s Hospital of Wisconsin Community Services and will not be effective regarding the uses
   or disclosures made prior to the cancellation.

Right to inspect or receive a copy of the information: You have a right to review and/or receive a copy (at a reasonable fee) of the
   information you authorized to be used or disclosed by this authorization. (There are certain legal restrictions to this that may be
   applicable; for example, a minor’s records cannot be released to parents who have been denied physical placement of the minor). You
   may arrange to inspect your file or obtain copies of this information disclosed by contacting Children’s Service Society of Wisconsin
   d/b/a Children’s Hospital of Wisconsin Community Services.

Prohibition on re-disclosure: The information and records being requested are protected under Federal and State confidentiality laws.
   Such laws prohibit the re-disclosure of such information unless further disclosure is expressly permitted by written consent or as
   otherwise permitted by laws. However, information disclosed may potentially be re-disclosed by the recipient and may no longer be
   protected by the federal privacy and confidentiality rules.

Client’s Signature: ___________________________ Date: ___________________________

AND/OR

Person Authorized to Sign for Client: ___________________________ Date: ___________________________

Specify Relationship to Client: ___________________________ Date: ___________________________

Witness: ___________________________ Date: ___________________________

Form of Verification: ☐ Personal knowledge ☐ Identification: (specify form) ___________________________

Federal Rules (42 CFR Part 2) restrict any use of this information to criminal...
AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: ___________________________ D.O.B.: ___________________________

(1) I/we, ____________________________ hereby request & authorize (specify program name) Institute for Child and Family Well-Being
of Children's Service Society of Wisconsin db/a Children's Hospital of Wisconsin-Community Services to:
☐: Disclose information and records to: (include name & address) _______________________________________

☐: Receive information and records from: (include name & address) _______________________________________

(2) Disclosure of this information is for the purpose of: (select which apply)
☒: Diagnoses, assessment, treatment or provision of services ☒: Legal purposes
☐: Insurance eligibility
☐: Other: (please specify) _______________________________________

(3) This authorization will expire:
☐: One time information sharing The information provided covers the time period ___________________________
Authorization expires 90 days from date of signature. Date of expiration ___________________________

OR

☒: Ongoing service provisions/continuity of care The information provided covers the time period 1 (one) year
Authorization will expire in one (1) year, unless an earlier date is specified. Date of expiration ___________________________

(4) Since a general authorization for the release of medical or other information is not sufficient for all purposes, the following specific information is requested. The specific information to be released from the records is as follows: (select which apply)

[ ] ☐: AODA Findings ☒: Education Findings ☒: Psychological Findings
[ ] ☐: Physical/Medical Findings ☒: Social Work Findings ☒: Recommendations
[ ] ☐: Psychiatric Findings ☒: Progress Notes & Findings ☒: Other: (specify) ___________________________

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to receive a copy of authorization: You have a right to receive a copy of this authorization.

Right to refuse to sign this authorization: You have the right to refuse to sign this authorization. You understand that this authorization is voluntary and that you may refuse to sign it. Unless allowed by law, your refusal to sign this authorization will not affect your ability to obtain treatment.

Right to withdraw this authorization: You have a right to withdraw this authorization at any time. You must submit written notification of your desire to cancel this authorization. You should be aware that your withdrawal will not be effective until received by Children's Service Society of Wisconsin db/a Children's Hospital of Wisconsin-Community Services and will not be effective regarding the uses or disclosures made prior to the cancellation.

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Prohibition on re-disclosure: The information and records being requested are protected under Federal and State confidentiality laws. Such laws prohibit the re-disclosure of such information unless further disclosure is expressly permitted by written consent or as otherwise permitted by laws. However, information disclosed may potentially be re-disclosed by the recipient and may no longer be protected by the federal privacy and confidentiality rules.

Client’s Signature: ___________________________ Date: ___________________________

[ ] ☐: Person Authorized to Sign for Client: ___________________________ Date: ___________________________

[ ] ☐: Specify Relationship to Client: ___________________________ Date: ___________________________

[ ] ☐: Witness: ___________________________ Date: ___________________________

Form of Verification: [ ] Personal knowledge [ ] Identification: (specify form) ___________________________

Federal Rules 42 CFR Part 2 prohibit any use of this information to criminally investigate or prosecute any alcohol or drug abuse client.