SOAR Case Management Services, Inc.
2132 Fordem Avenue
Madison, WI 53704
Ph. 608.287.0839 Fax 608.287.0840

CONSENT FOR REALEASE OF INFORMATION

I hereby authorize: **SOAR Case Management Service, Inc.**
2132 Fordem Avenue Madison, WI 53704

Agency and/or individual _____

Street/City/State/Zip _____

_____

☐ To release information to

☐ To obtain information from

(Check one box or both. By checking both, you are authorizing an exchange of Information between the agencies/ individuals listed.)

From the records of:

Client name:_____ Date of Birth:_____

Other names used:_____

Purpose or need for disclosure: _____

_____

Types of treatment information to be disclosed: ☐ Medical ☐ Mental Health

☐ Developmental Disability ☐ HIV ☐ Alcohol & Other Drug Abuse

Specific information to be disclosed:_____

_____

I understand that:

1. *My records are protected under State and Federal regulations governing confidentiality:*
   - ** Mental Health—Sec. 51.30, Wis. States; & HFS 92, Wis. Admin. Code*
   - ** Alcohol & Other Drug Abuse—42 CFR, Part 2; Sec. 51.30, Wis. Stats; & HFS 92, Wis. Admin Code*
   - ** Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, pts. 160 & 164*
2. *I will receive a copy of this form and have the right to inspect/receive a copy of materials to be disclosed.*
3. *Federal privacy law requires notification that my health information, once disclosed to individuals or organizations not subject to HIPPA, may no longer be protected by HIPPA. However, WI State statutes prohibit any individual or organizations receiving information from my mental health or alcohol/other drug abuse treatment records from disclosing that information further without my consent unless otherwise provided for in the regulations.*
4. *I am not required to sign this form and may refuse to do so. If I refuse to sign, SOAR Case Management Services may not deny me services, except as permitted under applicable law.*
5. *I have the right to revoke this authorization at any time by providing written notice to my SOAR provider or anyone at SOAR Case Management Services. Revocation of this authorization will not affect any action taken before receipt of the written revocation.*

This consent (unless revoked earlier) expires on _____

_____ _____
Client Signature Date

_____ _____
Signature of Guardian or Other Person Authorized to Consent Date

_____
Relationship to Client

_____ _____
Witness Date

A photocopy, fax, or electronic image of this consent shall be as valid as the original