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

CONSENT FOR RELEASE OF INFORMATION

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

☐ To release information to
☐ To obtain information from

Agency and/or individual ______________________________________

Street/City/State/Zip ______________________________________

____

(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: ______________________________________

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

☐Developmental Disability ☐ HIV ☐ Alcohol & Other Drug Abuse

Specific information to be disclosed:______________________________________

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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. Except as permitted under applicable law, SOAR Case Management may not deny me services because I refuse to sign.*
5. *I may revoke this consent at any time by giving notice to my SOAR service provider(s) or to anyone at SOAR Case Management, except to the extent that*

This consent (unless revoked earlier) expires on ______________________________________
(specify date, event or condition upon which expiration occurs)

______________________________________ ________________
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