DEPARTMENT OF HEALTH SERVICES
F-82009 (7/08)

STATE OF WISCONSIN
Sections 19.35 & 19.36, Wis. Stats.

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION W (08/2020)

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 & Address – **Agency/Organization I Authorize to Release Information**

Information May be Released To

Organization
University of Wisconsin-Population Health Institute

Address
610 Walnut Street

City, State, Zip Code
Madison, WI 53726

Specific Description of Records Authorized for Release

Wisconsin Program Participation System (PPS) Modules: Mental Health (MH) services and Alcohol and Other Drug Abuse (AODA) services and Mental Health and AODA Participations (Enrollment) including CRS.

Government Performance and Results Modernization Act of 2010 (GPRA) data collected through this program.

Information May be Released To
Division of Care and Treatment Services

Organization
Wisconsin Department of Health Services

Address
1 W. Wilson St.

City, State, Zip Code
Madison, WI 53703

Purpose or Need for Release of Information

This information is being collected as part of the State Opioid Response Grants implemented by the Wisconsin Department of Health Services (DHS) with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). The UW Population Health Institute is a partner with DHS on this project. The information collected through this program will provide key insight into the impact and progress of the program, and allow for an overall evaluation of these programmatic efforts. This program will operate from 9/30/2020 to 9/29/2022 or until the project ends. Providers offering services through this program will provide evidence-based treatment and services. Services may include a range of substance use related services such as, but not limited to, outpatient and residential treatment, use of peer recovery support specialists, medication assisted treatment and naloxone, and other recovery support services.

Understandings

- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:
  ☒ No exceptions ☐ Exceptions (specify):
- 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.
- Unless revoked, this authorization will remain in effect until the expiration time indicated below.

Choose One:

☐ Authorization expires as of _____ (Date).

☐ Authorization expires month(s) from the date I sign this authorization.

☒ Authorization expires after the following action takes place: Upon conclusion of this project.

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

SIGNATURE - Person Whose Records Will be Released (Record Subject)		Date Signed
SIGNATURE - Other Person Legally Authorized to Consent to Disclosure	Title or Relationship to Record Subject	Date Signed