ADDITIONAL INFORMATION REGARDING USE AND DISCLOSURE OF PROTECTED INFORMATION

The providers listed on this Authorization recognize your right to confidentiality of protected health care, mental health, and/or substance abuse treatment information as provided under federal and state laws.

This authorization only allows for the release of information from and between the organizations listed on the release form itself.

Please be aware of the following guidelines: |

Federal HIPAA Privacy Rules, State Health/Substance Confidentiality Statutes & Federal Substance Abuse Laws
There are situations when your protected information may be used or disclosed without your authorization and these situations will be explained to you upon request. Please contact your provider (health care, mental health and/or substance abuse), should you have questions about these rules/laws.

No Obligation to Sign
You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, you may not be denied services because you refuse to sign.

Revocation
You have the right to revoke this Authorization, in writing, at any time before it ends. Please contact any of the entities listed on the release and they will assist you. However, your written revocation will not affect any disclosures of your health and related information that the listed providers have already made, in reliance on this Authorization, before the time you revoke it.

Re-release
If the entities authorized by this form to disclose and/or receive your information/records are not subject to federal health privacy laws (for example, they are entities that do not provide health care, mental health or substance abuse treatment services), information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your information without your prior permission.

Right to Inspect
In authorizing a release of your health care, mental health or substance abuse records, you have the right to inspect and have a copy of the material you have given authorization to release, with certain exceptions provided under state and federal law. Should you wish to do this, please contact the relevant entity for further information.

Signatures
If you are 18 years of age or older, you are the only person who is permitted to sign this form to authorize the use or disclosure of your health, mental health and/or substance abuse treatment record, unless you have a legal guardian or a health care power of attorney or agent. If you are under the age of 18, your parent (or legal guardian) has the right to sign this form for you. However, there are situations under state law where you, as a minor, are either permitted or required to consent to the release of information by signing this form in lieu of a parent or guardian. For more information regarding who is authorized to sign this form, please contact any of the entities listed on the release and they will assist you.

Participant Rights and Responsibilities
If you have a complaint about the services you receive through the Madison/Dane CoC Coordinated Entry System, you have the right to file a grievance. Copies of the Participant Rights and Responsibilities form are available at the following locations: The Beacon, Porchlight, The Salvation Army, Tenant Resource Center, or at www.danecountyhomeless.org.