Dane County Familiar Faces Project Reciprocal Authorization for Disclosure of Confidential Information for Service Access and Coordination

1. Person whose information will be released:

Name: _____ Date of birth: _____

2. Purpose of disclosure:

The Dane County Familiar Faces Project aims to do the following, and agencies authorized under this form agree to share the minimum amount of information necessary to fulfill these purposes:

- Identify individuals in Dane County with high levels of involvement in systems of emergency care (such as emergency medical services, behavioral health crisis services, psychiatric hospitalization, detox, homeless day services and outreach, emergency shelter, and jail)
- Improve collaboration and coordination of current services and connect individuals to additional supports
- Identify and work toward offering new interventions or approaches to support quality of life and independence

3. Type of information/records authorized for release:

By signing this release, an individual (or their legal representative) authorizes sharing of the following information for the purposes listed above:

- Contact information including email and phone number
- Homeless status and housing history
- Diagnoses and services needs related to mental and physical health, alcohol and other drug use, HIV/AIDS related illness or test results, and developmental disabilities
- Enrollment in and utilization of programs and services
- Income and benefits
- Basic demographic information

4. Entities authorized to share information

By signing this release, an individual (or their legal representative) authorizes information to be release by each, any, and all of the following to each, any, and all of the following, limited to the purpose, scope, and duration identified. This consent applies to all programs and services operated by the listed agency.

Catalyst for Change	Catholic Charities of Madison
City of Madison Community Development Div.	Dane County Dept. of Human Services
Dane County Reentry Coordinator	Journey Mental Health Center
Madison Street Medicine	Porchlight, Inc.
Tellurian UCAN	The Salvation Army Dane County
UnityPoint Health - Meriter	Urban Triage

Please list other agencies providing services (e.g. mental health case management, supportive housing, outreach, etc.) that you wish to coordinate with the FPP on your behalf and for which you authorize reciprocal information sharing:

Your signature below indicates that you understand and are providing informed consent for this information sharing to occur. Authorization is valid for two years, unless you choose to revoke it sooner. By signing, you acknowledge that you have reviewed your rights and have received a copy of this form and the *Additional Information Regarding Use and Disclosure of Protected Information.*

_____ _____

Signature of Participant (or legal representative) | Relationship / legal authority to sign (if not signed by participant)

_____ _____

Witness Signature | Witness printed name and agency or affiliation

_____

Date

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 healthcare 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.