DEPARTMENT OF CORRECTIONS
Division of Management Services
DOC-1163 (Rev. 3/2021)

WISCONSIN
Wisconsin Statutes - Sections 19.35, 19.36, 19.62(5), 118.125, 134.98 and 938.78
Federal Regulations 42 CFR Part 2 & 45 Parts 160 & 164
20 U.S.C. § 1232g; 34 CFR Part 99

AUTHORIZATION FOR DISCLOSURE OF NON-HEALTH CONFIDENTIAL RECORDS

NOTICE: DO NOT USE TO AUTHORIZE DISCLOSURE OF PROTECTED HEALTH RECORDS. USE FORM DOC-1163A

INDIVIDUAL/AGENCY BEING AUTHORIZED TO RELEASE RECORD(S)

NAME OF INDIVIDUAL / AGENCY	TELEPHONE NUMBER	FAX NUMBER
Wisconsin Division of Juvenile Corrections - The Grow Academy	608-240-5900	608-240-3370

ADDRESS	CITY	STATE	ZIP CODE
PO Box 8930	Madison	WI	53708

SUBJECT OF RECORD(S)

NAME	IDENTIFYING/DOC NUMBER	DATE OF BIRTH
1.	2.	3.

ADDRESS	CITY	STATE	ZIP CODE
4.	5.	6.	7.

RECORD(S) MAY BE RELEASED TO

NAME OF INDIVIDUAL / AGENCY	TELEPHONE NUMBER	FAX NUMBER
Various Media & Community Partners		

ADDRESS	CITY	STATE	ZIP CODE

SPECIFIC INFORMATION AUTHORIZED FOR DISCLOSURE

I understand that the information I am authorizing for release may contain my Personally Identifiable Information (PII) such as my complete date of birth, driver's license number, state ID number, social security number or other personal information as defined in Wis. Stat. § 134.98.

I understand that for release of my Protected Health Information (PHI), I must submit a signed DOC-1163A for disclosure of any of my health / treatment information including Alcohol & Other Drug Abuse (AODA) / Substance Use Disorder (SUD) treatment, mental health information or other Protected Health Information, etc.

INSTRUCTIONS: Check All That Apply Below

ADULT - DIVISION OF ADULT INSTITUTIONS (DAI) AND DIVISION OF COMMUNITY CORRECTIONS (DCC):

☐ **DAI - Institution Social Service File (Use DOC-1163A for disclosure of information relating to therapy/counseling provided by DOC treatment staff or any other health information.)**

☐ **DAI – Legal File**

☐ **DCC - Client Case File**

☐ **Juvenile record information included in DOC adult records**

☐ **Specific record(s) authorized for release:** _____

Identify Time Period Of Records –
If no start and end dates are indicated, only records pertinent to the last 12 months will be provided.

YOUTH - DIVISION OF JUVENILE CORRECTIONS (DJC): Records pertaining to a juvenile as allowable under Wis. Stat. § 938.78(2)

☐ **DJC Facility Case File** ☐ **DJC Field Case File**

☐ **Specific record(s) authorized for release:** _____

Identify Time Period Of Records –
If no start and end dates are indicated, only records pertinent to the last 12 months will be provided.

Continued

☐ **EDUCATION - Complete for adult and/or juvenile student education records:** ☐ **ADULT** ☐ **YOUTH / JUVENILE**

☐ Regular education information/records (including attendance records)
☐ SPED information/record(s) e.g. IEP, MMPI, M-Team, etc.
☐ High school credits
☐ Disciplinary Actions
☐ High School Transcript
☐ GED or HSED Scores
☐ Vocational/technical school or college transcript
☐ Other: _____

☐ Purpose for disclosure of education records (required): _____

Identify Time Period Of Records –

OTHER

Identify Time Period of Records: Valid unti discharge from Grow Academy

Type(s) of information / record(s): Marketing material, media, tours & stakeholder presentations; may disclose identity

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Signing of Authorization - I am under no legal obligation to sign this authorization. If I do, I have a right to receive a copy.

AODA/SUD Record(s) - My record(s) may contain alcohol and other drug abuse information. If so, I must sign DOC-1163A or that information will be redacted before the Protected Health Information (PHI) record(s) are released.

Re-disclosure of Information/Record(s) - If I authorize release of record(s) to an individual or agency covered by federal or state laws that prohibit re-disclosure, the recipient cannot re-disclose the records without a signed information release from me, a court order or other specific authorization under the law. However, if I consent to release record(s) to an individual/agency not covered by federal or state laws that prohibit re-disclosure, my private record(s) may not remain confidential.

Right to Inspect and/or Copy Information/Record(s) - I have the right to inspect and copy my records as permitted under state and federal law. I may be charged a reasonable fee for copies.

REQUIRED: COMPLETE ENTIRE SECTION BELOW - AUTHORIZATION SIGNATURE AND EXPIRATION

INITIAL ONE OPTION ONLY BELOW (Required)

☐ Authorization expires as of: Date

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

☐ Authorization expires after the following action takes place: valid until discharge from Grow Academy

☐ Authorization expires upon substantial change in criminal justice system status. (e.g., released from prison.)

I have read or had read to me the contents of this authorization. I have had an opportunity to discuss and ask questions, and understand the purpose of this authorization request. By signing and dating this authorization, I am confirming that it accurately reflects my wishes regarding disclosure of my confidential information.

SIGNATURE OF INDIVIDUAL WHO IS SUBJECT OF RECORD*#		DATE SIGNED
SIGNATURE OF OTHER PERSON LEGALLY AUTHORIZED TO CONSENT TO DISCLOSURE (If Applicable)*#	TITLE OR RELATIONSHIP TO INDIVIDUAL WHO IS SUBJECT OF RECORD	DATE SIGNED

* Youth/Juvenile Records: The authorization must specify the record(s) and the party to whom the record(s) may be disclosed. It must be signed by the parent, guardian, or legal custodian of the juvenile who is the subject of the record, or the juvenile, if 14 years of age or older, per Wis. Stat. § 938.78(am).

Education/Student Records: The authorization must be signed and dated by the parent, guardian or individual acting as a parent in the absence of a parent/guardian, or by an "eligible student" (18 years of age or older or under 18 and attending a postsecondary institution). It must specify the record(s) that may be disclosed, state the purpose of the disclosure, and identify the party or class of parties to whom the disclosure may be made, per 34 CFR § 99.30(b).

FAX OR PHOTOCOPY MAY BE TREATED AS ORIGINAL

DISTRIBUTION: Original- Individual/Agency authorized to release Information/Record(s); Official Record-Appropriate Offender Education/Social Service File, Release of Information Authorizations Section; Copy-Offender/Other Person Signing Release

DEPARTMENT OF CORRECTIONS
Division of Management Services
DOC-1163A (Rev. 12/2020)

WISCONSIN
Wisconsin Statutes
§§ 146.81-84, 252.15, 938.78 and 51.30
Federal Regulations
42 CFR Part 2 & 45 CFR Parts 160 & 164

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

INDIVIDUAL / AGENCY BEING AUTHORIZED TO DISCLOSE PHI

NAME OF INDIVIDUAL / AGENCY	TELEPHONE NUMBER	FAX NUMBER
Grow Academy	608-835-5700	608-288-3378

ADDRESS	CITY	STATE	ZIP CODE
4986 County Hwy M	Oregon	WI	53575

SUBJECT OF PROTECTED HEALTH INFORMATION (PATIENT)

PATIENT NAME	DOC NUMBER	HOUSING UNIT	DATE OF BIRTH	TELEPHONE NUMBER

ADDRESS	CITY	STATE	ZIP CODE

RECIPIENT OF PROTECTED HEALTH INFORMATION

NAME OF INDIVIDUAL / AGENCY (e.g. Lawyer, Physician, Patient, Family)	TELEPHONE NUMBER	FAX NUMBER
Anesis Therapy Center	608-268-6530	608-709-1744

ADDRESS	CITY	STATE	ZIP CODE
6417 Odana Road, Ste 5	Madison	WI	53719

NOTICE: Records of the Department of Corrections that contain Protected Health Information (PHI) may include a Division of Adult Institutions and/or Division of Juvenile Corrections Health Care Record, Social Services File or Division of Community Corrections file. The records include those created by DOC and non-DOC health care providers. Disclosure of PHI can be written, electronic or verbal.
READ CAREFULLY AND CHECK APPROPRIATE BOXES.

SPECIFIC PROTECTED HEALTH INFORMATION AUTHORIZED FOR USE/ DISCLOSURE

☒ **Two-Way Release** By checking this box, I authorize the individuals/agencies named in this authorization, to disclose to each other, the PHI identified below on an ongoing basis for the duration of this authorization.

☐ **Check the box to the left if a copy of an entire record may be disclosed and explain below why the entire record is needed.** Entire record includes all the types of information listed below plus correspondence, consents/refusals, medication administration sheets, flow sheets and miscellaneous documents. **If this box is checked, no checkboxes in the section below need to be checked**. **If no start and end dates are given below, only the last 12 months will be provided.**

DOCUMENTS AUTHORIZED FOR USE/DISCLOSURE

☒ Problem List
☐ Record of Immunizations and TB test Results
☐ Medical History/Physical Exam
☒ Progress Notes
☒ Prescriber's Orders/Medications
☐ Consultations
☐ Laboratory Results
☐ Medical Imaging Reports (X-Rays, MRIs, etc.)
☒ Psychiatric (may include AODA/SUD diagnoses)
☒ Psychological (may include AODA/SUD diagnoses)
☒ AODA / SUD Program/Treatment Information
☐ Optical
☐ Dental
☐ Patient Request Folder/OnBase (e.g. Health Service Requests, Medication/Medical Supply Refill Requests)

THIS AUTHORIZATION MAY INCLUDE MEDICAL, MENTAL HEALTH, DEVELOPMENTAL DISABILITY AND ALCOHOL/DRUG ABUSE/SUBSTANCE USE DISORDER INFORMATION, AND HIV TEST RESULTS, UNLESS EXCLUDED BELOW.

Describe time period of records by entering start and end dates. If no dates are entered, records for the most recent 12 months will be provided. FROM: TO:

If Authorization is **limited** to or includes specific youth/juvenile medical or mental health conditions(s), describe (include time period):

☐ **LOCATION**: I authorize the disclosure of my location knowing that this will reveal that I am in a mental health or AODA / SUD treatment facility.

PURPOSE OR NEED FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (check applicable category)

☐ Ongoing health care/treatment
☐ Further Medical Care
☐ Review by patient
☐ Review by family member/friend
☐ Legal representation/proceedings (Court/Administrative)
☐ Disability/Social Security Determination
☒ Other Coordination of care or eligibility for services/benefits

Continued

PATIENT NAME	DOC NUMBER

PATIENT RIGHTS

Right to Receive Copy of This Authorization. Patients have a right to receive a copy of this form after signing it.

Right to Refuse to Sign This Authorization. DOC can not condition treatment or payment for treatment based on a patient's decision not to sign this form, except for research-related treatment and provision of health care solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization. Patients have the right to revoke this Authorization at any time by completing a Revocation of Authorization for Use/Disclosure of PHI (DOC-1163R), or equivalent. Revocation is effective when DOC, or other individual/agency authorized to disclose PHI, receives the form, and is not effective regarding the uses/disclosures of PHI made prior to receipt of the DOC-1163R, or equivalent.

Re-disclosure. If a patient authorizes disclosure to an individual/agency not covered by laws that prohibit re-disclosure, the PHI may be re-disclosed by that individual/agency. If Substance Use Disorder (SUD/AODA) records have been disclosed:

- The record that has been disclosed is protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except provided under §§ 2.12(c)(5) and 2.65.

Right to Inspect and/or Copy PHI. Patients have the right to inspect, and obtain copies of PHI for a reasonable fee used/disclosed based upon this form.

Authority to Sign DOC-1163A. A **minor** is a person under the age of 18 years. An **adult i**s a person 18 years or older.

- Adults can sign the form regarding all types of PHI about themselves.
- A court appointed guardian of the person or an agent under an activated Power of Attorney for Health Care (POAHC) can sign the form for the incompetent adult or principal regarding all types of PHI, unless restricted by the Letters of Guardianship or POAHC document.
- A parent/guardian can sign the form for a minor child regarding medical/ physical health, mental health and developmental disability information.
- Minors 12-17 years can sign the form for AODA / SUD information about themselves. A parent/guardian can **not** access or authorize disclosure of AODA / SUD information about a minor child 12-17 years without consent of the minor.
- Minors 14 -17 years old can sign the form regarding mental health and developmental disability information about themselves from a community provider whose records are covered by s. 51.30, Wis. Stats.
- Minors 14 -17 years can sign the form regarding HIV test results about themselves. A parent/guardian can **not** access or authorize disclosure of HIV information about a minor child 14-17 years without consent of the minor.

AUTHORIZATION EXPIRATION: DATE/EVENT

This Authorization is in effect until the following date or event: _____

If no date/event is entered, this Authorization expires one year from the date of signing.

I have read or had read to me this Authorization form. I have had an opportunity to ask questions. By signing this Authorization, I am confirming that it accurately reflects my wishes regarding use and disclosure of my Protected Health Information. I understand that there may be a charge for copies.

SIGNATURE OF PATIENT:		DATE SIGNED[1]
SIGNATURE OF OTHER PERSON LEGALLY AUTHORIZED TO CONSENT TO DISCLOSURE (If Applicable):	RELATIONSHIP TO PATIENT ☐ Legal Guardian ☐ Parent of Minor ☐ Next of Kin ☐ Health Care Agent ☐ Personal Representative ☐ Other:	DATE SIGNED[2]

FACSIMILE OR PHOTOCOPY CAN BE TREATED AS ORIGINAL

DISTRIBUTION: Original – Internal Paper Record, PR Authorization Section; Social Services File, Release of Information Authorizations Section; PSU Record AODA / SUD Envelope or DCC Client Case File; Copy - Individual/Agency authorized to disclose PHI when other than DOC Copy - Patient /Other Person signing form

DEPARTMENT OF CORRECTIONS
Division of Management Services
DOC-1163A (Rev. 12/2020)

WISCONSIN
Wisconsin Statutes
§§ 146.81-84, 252.15, 938.78 and 51.30
Federal Regulations
42 CFR Part 2 & 45 CFR Parts 160 & 164

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

INDIVIDUAL / AGENCY BEING AUTHORIZED TO DISCLOSE PHI

NAME OF INDIVIDUAL / AGENCY			TELEPHONE NUMBER	FAX NUMBER
Grow Academy			608-835-5700	608-288-3378
ADDRESS	CITY		STATE	ZIP CODE
4986 County Hwy M	Oregon		WI	53575

SUBJECT OF PROTECTED HEALTH INFORMATION (PATIENT)

PATIENT NAME	DOC NUMBER	HOUSING UNIT	DATE OF BIRTH	TELEPHONE NUMBER
ADDRESS	CITY		STATE	ZIP CODE

RECIPIENT OF PROTECTED HEALTH INFORMATION

NAME OF INDIVIDUAL / AGENCY (e.g. Lawyer, Physician, Patient, Family)		TELEPHONE NUMBER	FAX NUMBER
Henger Enterprises LTD		608-728-4358	
ADDRESS	CITY	STATE	ZIP CODE
735 N Water Street, Ste 519	Milwaukee	WI	53202

NOTICE: Records of the Department of Corrections that contain Protected Health Information (PHI) may include a Division of Adult Institutions and/or Division of Juvenile Corrections Health Care Record, Social Services File or Division of Community Corrections file. The records include those created by DOC and non-DOC health care providers. Disclosure of PHI can be written, electronic or verbal.
READ CAREFULLY AND CHECK APPROPRIATE BOXES.

SPECIFIC PROTECTED HEALTH INFORMATION AUTHORIZED FOR USE/ DISCLOSURE

☒ **Two-Way Release** By checking this box, I authorize the individuals/agencies named in this authorization, to disclose to each other, the PHI identified below on an ongoing basis for the duration of this authorization.

☐ **Check the box to the left if a copy of an entire record may be disclosed and explain below why the entire record is needed.** Entire record includes all the types of information listed below plus correspondence, consents/refusals, medication administration sheets, flow sheets and miscellaneous documents. **If this box is checked, no checkboxes in the section below need to be checked**. **If no start and end dates are given below, only the last 12 months will be provided.**

DOCUMENTS AUTHORIZED FOR USE/DISCLOSURE

☒ Problem List
☐ Record of Immunizations and TB test Results
☐ Medical History/Physical Exam
☐ Progress Notes
☐ Prescriber's Orders/Medications
☐ Consultations
☐ Laboratory Results
☐ Medical Imaging Reports (X-Rays, MRIs, etc.)
☒ Psychiatric (may include AODA/SUD diagnoses)
☒ Psychological (may include AODA/SUD diagnoses)
☒ AODA / SUD Program/Treatment Information
☐ Optical
☐ Dental
☐ Patient Request Folder/OnBase (e.g. Health Service Requests, Medication/Medical Supply Refill Requests)

THIS AUTHORIZATION MAY INCLUDE MEDICAL, MENTAL HEALTH, DEVELOPMENTAL DISABILITY AND ALCOHOL/DRUG ABUSE/SUBSTANCE USE DISORDER INFORMATION, AND HIV TEST RESULTS, UNLESS EXCLUDED BELOW.

Describe time period of records by entering start and end dates. If no dates are entered, records for the most recent 12 months will be provided. FROM: TO:

If Authorization is **limited** to or includes specific youth/juvenile medical or mental health conditions(s), describe (include time period):

☐ **LOCATION**: I authorize the disclosure of my location knowing that this will reveal that I am in a mental health or AODA / SUD treatment facility.

PURPOSE OR NEED FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (check applicable category)

☐ Ongoing health care/treatment
☐ Further Medical Care
☐ Review by patient
☐ Review by family member/friend
☐ Legal representation/proceedings (Court/Administrative)
☐ Disability/Social Security Determination
☒ Other Coordination of care or eligibility for services/benefits; for use in referral to Thinking for a Change and ongoing communication/collaboration with group facilitator(s) and Grow Treatment Specialist

Continued

PATIENT NAME	DOC NUMBER

PATIENT RIGHTS

Right to Receive Copy of This Authorization. Patients have a right to receive a copy of this form after signing it.

Right to Refuse to Sign This Authorization. DOC can not condition treatment or payment for treatment based on a patient's decision not to sign this form, except for research-related treatment and provision of health care solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization. Patients have the right to revoke this Authorization at any time by completing a Revocation of Authorization for Use/Disclosure of PHI (DOC-1163R), or equivalent. Revocation is effective when DOC, or other individual/agency authorized to disclose PHI, receives the form, and is not effective regarding the uses/disclosures of PHI made prior to receipt of the DOC-1163R, or equivalent.

Re-disclosure. If a patient authorizes disclosure to an individual/agency not covered by laws that prohibit re-disclosure, the PHI may be re-disclosed by that individual/agency. If Substance Use Disorder (SUD/AODA) records have been disclosed:

- The record that has been disclosed is protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except provided under §§ 2.12(c)(5) and 2.65.

Right to Inspect and/or Copy PHI. Patients have the right to inspect, and obtain copies of PHI for a reasonable fee used/disclosed based upon this form.

Authority to Sign DOC-1163A. A **minor** is a person under the age of 18 years. An **adult i**s a person 18 years or older.

- Adults can sign the form regarding all types of PHI about themselves.
- A court appointed guardian of the person or an agent under an activated Power of Attorney for Health Care (POAHC) can sign the form for the incompetent adult or principal regarding all types of PHI, unless restricted by the Letters of Guardianship or POAHC document.
- A parent/guardian can sign the form for a minor child regarding medical/ physical health, mental health and developmental disability information.
- Minors 12-17 years can sign the form for AODA / SUD information about themselves. A parent/guardian can **not** access or authorize disclosure of AODA / SUD information about a minor child 12-17 years without consent of the minor.
- Minors 14 -17 years old can sign the form regarding mental health and developmental disability information about themselves from a community provider whose records are covered by s. 51.30, Wis. Stats.
- Minors 14 -17 years can sign the form regarding HIV test results about themselves. A parent/guardian can **not** access or authorize disclosure of HIV information about a minor child 14-17 years without consent of the minor.

AUTHORIZATION EXPIRATION: DATE/EVENT

This Authorization is in effect until the following date or event: _____

If no date/event is entered, this Authorization expires one year from the date of signing.

I have read or had read to me this Authorization form. I have had an opportunity to ask questions. By signing this Authorization, I am confirming that it accurately reflects my wishes regarding use and disclosure of my Protected Health Information. I understand that there may be a charge for copies.

SIGNATURE OF PATIENT:		DATE SIGNED[1]
SIGNATURE OF OTHER PERSON LEGALLY AUTHORIZED TO CONSENT TO DISCLOSURE (If Applicable):	RELATIONSHIP TO PATIENT ☐ Legal Guardian ☐ Parent of Minor ☐ Next of Kin ☐ Health Care Agent ☐ Personal Representative ☐ Other:	DATE SIGNED[2]

FACSIMILE OR PHOTOCOPY CAN BE TREATED AS ORIGINAL

DISTRIBUTION: Original – Internal Paper Record, PR Authorization Section; Social Services File, Release of Information Authorizations Section; PSU Record AODA / SUD Envelope or DCC Client Case File; Copy - Individual/Agency authorized to disclose PHI when other than DOC Copy - Patient /Other Person signing form