DEPARTMENT OF CORRECTIONS
Division of Management Services
DOC-1163 (Rev. 8/2018)

WISCONSIN
Wisconsin Statutes - Sections 19.35, 19.36 & 118.125
Federal Regulations 42 CFR Part 2 & 45 CFR Parts 160 & 164

AUTHORIZATION FOR DISCLOSURE OF NON-HEALTH CONFIDENTIAL INFORMATION

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

INDIVIDUAL/AGENCY BEING AUTHORIZED TO RELEASE INFORMATION/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 INFORMATION/RECORD(S)

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

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

INFORMATION/RECORD(S) MAY BE RELEASED TO

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

ADDRESS	CITY	STATE	ZIP CODE

SPECIFIC INFORMATION AUTHORIZED FOR DISCLOSURE

INSTRUCTIONS: Check All That Apply

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

☐ **Legal**

☐ **Division of Community Corrections File** (Use DOC-1163A for disclosure of any health information.)

☒ **Two-way Release** By checking this box I authorize the individual/agency named in this authorization, to RELEASE TO EACH OTHER, only the information/records listed for release on this form in the category(ies) below. I authorize this exchange of information on an ongoing basis for the duration of this authorization.

I understand that the information I am authorizing for release may contain Personally Identifiable Information (PII) such as complete date of birth, driver's license number, state ID number or social security number.

Check the category(ies) and sub-categories of information authorized for release.

☐ EDUCATION

Identify Time Period Of Records: _____

☐ 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: ☐ To assist in educational/vocational planning ☐ Other: _____

Purpose: ☐ To complete PSI

☐ EMPLOYMENT

Identify Time Period Of Records: _____

☐ Period(s) of employment ☐ Job performance evaluation(s) ☐ Job attendance ☐ Job duties & title

Purpose: ☐ To assist in career planning ☐ Other _____

Continued

Purpose: ☐ To complete PSI

☒ **OTHER** Marketing material, media, tours and stakeholder presentations; may disclose identity

Identify Time Period Of Records:

Type(s) or information/record(s):

Purpose:

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 Information - My educational information/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 education information/record(s) are released.

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

Right to Inspect and/or Copy Education Information/Records - I have the right to inspect and copy my educational records as permitted under s. 118.125 Wis. Stats. I may be charged a reasonable fee for copies.

AUTHORIZATION SIGNATURE

INITIAL ONE ONLY (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:

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

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

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

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. 5/2019)

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	

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
1.			2.	3.

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

RECIPIENT OF PROTECTED HEALTH INFORMATION

NAME OF INDIVIDUAL / AGENCY	TELEPHONE NUMBER	FAX NUMBER
Anesis Therapy Center	608-268-6530	608-709-1744

ADDRESS	CITY	STATE	ZIP CODE
6417 Odana Rd 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 specific medical or mental health conditions(s), describe:

☐ **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 ☐ Review by patient ☐ Legal representation/proceedings (Court/Administrative)
☒ Coordination of care or eligibility for services/benefits. ☐ Review by family member/friend.
☐ Other

Continued

PATIENT NAME **8.**	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.

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.

SIGNATURE OF PATIENT		DATE SIGNED
SIGNATURE OF OTHER PERSON LEGALLY AUTHORIZED TO CONSENT TO DISCLOSURE (If Applicable)	TITLE OR RELATIONSHIP TO PATIENT	DATE SIGNED

LIST OF DOCUMENTS/INFORMATION DISCLOSED BASED UPON THIS AUTHORIZATION
(Write on back-side of form or attach additional sheets if needed, include name and DOC number on each sheet)

INITIALS OF PERSON DISCLOSING PHI _____ DATE DISCLOSED _____ TIME DISCLOSED _____

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 Offender Case File; Copy - Individual/Agency authorized to disclose PHI when other than DOC Copy - Patient /Other Person signing form

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RECIPIENT OF PROTECTED HEALTH INFORMATION

NAME OF INDIVIDUAL / AGENCY	TELEPHONE NUMBER	FAX NUMBER
Henger Enterprises LTD	608-728-4358	

ADDRESS	CITY	STATE	ZIP CODE
735 N Water Street, Ste 519	Milwaukee	WI	53202

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

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

Continued

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