

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
ADDRESS	CITY	STATE	ZIP CODE

SUBJECT OF INFORMATION/RECORD(S)

NAME		IDENTIFYING/DOC NUMBER	DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP CODE

INFORMATION/RECORD(S) MAY BE RELEASED TO

NAME OF INDIVIDUAL / AGENCY		TELEPHONE NUMBER	FAX NUMBER
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

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); Copy-Offender/Other Person Signing Release; Official Record-Appropriate Offender Education/Legal File, Right Side/Social Service File, Left Side