DEPARTMENT OF CORRECTIONS
Division of Management Services
DOC-1163A (Rev. 2/2023)

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
WI DOC		

ADDRESS	CITY	STATE	ZIP CODE
3099 E Washington Ave	Madison	WI	53704

SUBJECT OF PROTECTED HEALTH INFORMATION (PATIENT)

PATIENT NAME	DOC NUMBER	HOUSING UNIT	DATE OF BIRTH	TELEPHONE NUMBER

ADDRESS	CITY	STATE	ZIP CODE

RECIPIENT(S) OF PROTECTED HEALTH INFORMATION

NAME OF INDIVIDUAL(S) / ORGANIZATON(S) (e.g. Lawyer, Physician, Patient, Family)	TELEPHONE NUMBER	FAX NUMBER
Windows to Work Coach		

ADDRESS	CITY	STATE	ZIP CODE

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
☐ Specific Form Numbers:
☐ 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: First DAI Admission Date TO: Discharge Date of W2W

If Authorization is **limited** to medical or mental health conditions(s), or includes specific youth/juvenile information, 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
☒ Other Windows to Work Program
☐ Review by patient
☐ Review by family member/friend
☐ Legal representation/proceedings (Court/Administrative)
☐ Disability/Social Security Determination

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: **Discharge from Windows to Work Program**

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]

FOR CENTRAL MEDICAL RECORDS AND INACTIVE WOMEN'S MEDICAL RECORD USE ONLY:

LIST OF DOCUMENTS / INFORMATION DISCLOSED, BASED ON THIS AUTHORIZATION (Write on back side of form or attach additional sheet(s), if needed. Include name and DOC on each sheet.)

Initials of Person disclosing PHI _____ Date Disclosed _____ Time Disclosed _____

FACSIMILE OR PHOTOCOPY CAN BE TREATED AS ORIGINAL

DISTRIBUTION: Original-HIM Forms/Documents-Authorization Documents: HSU scan to PR Medical Authorization, PSU scan to PR Psychological Authorization, SUD scan to PR SUD Authorization; or DCC Client Case File; or Social Services File, Release of Information Authorizations Section when applicable. Copy – Patient/Other Person signing form. Copy – Individual/Agency authorized to disclose PHI when other than DOC.