

 <b>WRAPAROUND MILWAUKEE POLICY &amp; PROCEDURE</b>	Date Issued: <b>9/1/98</b>	Date Revised: <b>9/23/08</b>	Section: <b>ADMINISTRATION</b>	Policy No: <b>011</b>	Pages: <b>1 of 2</b> (4 Attachments)
	<input checked="" type="checkbox"/> Wraparound <input checked="" type="checkbox"/> Wraparound/REACH <input type="checkbox"/> FISS	Effective Date: <b>1/1/09</b>	Subject: <b>CONSENT / ACKNOWLEDGEMENT AND AUTHORIZATION FORMS</b>		

## I. POLICY

It is the policy of Wraparound Milwaukee / REACH to have the youth and a parent/legal guardian sign the identified Consent/Acknowledgment and Authorization For Release of Information forms during the initial contact that the Care Coordinator has with the family. The initial contact must occur within the first seven (7) calendar days of enrollment (*first 5 working days*).

The purpose of the Consent/Acknowledgement Form is to receive permission from the youth and parent or legal guardian for the following:

- CONSENT/ACKNOWLEDGEMENT FORM (*see Attachment 1*) - to allow Wraparound Milwaukee /REACH personnel and/or providers/identified persons to transport youth, to acknowledge receipt of the Client Rights and Complaint/Grievance Procedure handout, and to acknowledge receipt of the Wraparound HIPAA Privacy Statement.

The purpose of the Authorization for Release of Information Form is to receive permission from the youth and parent/legal guardian for the following:

- AUTHORIZATION FOR RELEASE OF INFORMATION forms (*see Attachment 2 for Wraparound and Attachment 3 for REACH*) - to allow Wraparound Milwaukee / REACH personnel to give or receive information with or from specific identified agencies/persons.

*Note: Also see Mobile Urgent Treatment Team (MUTT) Consent for Treatment Policy (#027).*

## II. PROCEDURE

The Care Coordinator will receive the necessary Consent/Acknowledgement and Authorization for Release of Information Forms in the enrollment packet when they are assigned to work with a family.

The Care Coordinator is responsible for getting the necessary signatures during the first visit with the youth/family, which must occur during the first week of enrollment (*first 5 working days*).

Wraparound youth under the age of 14 (at admission) are not required to sign the Wraparound or MUTT Consent Forms. Youth age 14 and older should sign, but if a youth's signature cannot be obtained for whatever reason, the parent's/legal guardian's signature alone will suffice. If a youth is not 14 years of age when he/she enters the program, but turns 14 during the course of the first year in Wraparound, he/she should sign the Consents at the one year time frame when all Consents need to be renewed/resigned.

*Note: Exchange of information and formal Wraparound / REACH services cannot legally occur without the forms being signed.*

The Forms must then become a permanent part of the youth's file. Copies must be shared with identified parties as information needs to be shared/given/received.

All Consent/Acknowledgement and Authorization forms expire 12 months from the date they were signed







**AUTHORIZATION FOR RELEASE OF INFORMATION**

**PURPOSE OF DISCLOSURE:**

Release of Mental Health and AODA (Alcohol and Other Drug Addiction) and physical health information that will be used to plan and provide for the care, treatment and services for:

\_\_\_\_\_  
 (Youth's Name)

\_\_\_\_\_  
 (Date of Birth)

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and/or the Mobile Urgent Treatment Team to release/exchange health related information including diagnosis, prognosis, treatment and planning related to the above named youth's enrollment in Wraparound Milwaukee to the appropriate staff at the following agency/s that authorize enrollment or provide emergency services for families enrolled in the Wraparound Milwaukee program.

- Milwaukee County Children's Court
- Medicaid/Title 19
- Bureau of Milwaukee Child Welfare

Additionally, information as indicated below may be released to/received from the following:

**SHARED DOCUMENTS/INFORMATION**

(Check those that apply.)

	Demographic Information Only	Plan of Care	Referral for Services	Other * (See Below)
Milwaukee Public Schools/other school _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Families United of Milwaukee, Inc. (Family Advocate): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Physician: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Services Provider: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____ Agency/Individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____ Agency/Individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*Other Document/s: \_\_\_\_\_

**CONSENT FOR INFORMATION TO BE USED IN RESEARCH**

I give my consent for non-identifying evaluation data obtained during my enrollment in Wraparound to be used for research to evaluate the effectiveness of the program. I understand that this research may be presented at conferences, universities and in publications. I understand that information collected for this research is part of the usual Wraparound evaluation procedures. I understand that my family's confidentiality will be protected. No information that is presented to the public will contain any identifying information such as name, address or telephone number.

**EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION**

If not specified below, I understand that **this Authorization for Release of Information EXPIRES 12 MONTHS from the date it was signed.** I understand that I may cancel this authorization at any time (see back of sheet for instructions). This does not include any information that has been shared between the time I gave my consent to share information and the time that the consent was canceled.

This authorization expires on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

**REDISCLASURE NOTICE:** I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

\_\_\_\_\_  
 Parent or Legal Guardian Signature Date

\_\_\_\_\_  
 Youth Signature (age 14 and older should sign) Date

\_\_\_\_\_  
 Witness Signature Date

## **CLIENT RIGHTS RELATED TO AUTHORIZATION FOR RELEASE OF INFORMATION**

### **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**Right to Receive Copy of This Authorization** - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

**Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

**Failure to Sign** - I understand that failure to sign this authorization may severely limit the treatment / service options available for my child or family and/or may result in a request to the courts to modify the court order that allows for enrollment in the Wraparound Milwaukee program.

**Right to Withdraw This Authorization** - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Pamela Erdman, Wraparound Milwaukee Quality Assurance. (The statement must be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that Wraparound Milwaukee has made prior to receipt of my withdrawal statement

**Right to Inspect or Copy the Health Information to Be Used or Disclosed** - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department.

**HIV Test Results** - I understand my child's HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

### **Submit your written requests for withdrawal to:**

Ms. Pamela Erdman, Wraparound Milwaukee Quality Assurance Director  
Wraparound Milwaukee Administrative Offices  
9201 Watertown Plank Road  
Milwaukee, WI 53226                      Phone: (414) 257-7608



**AUTHORIZATION FOR RELEASE OF INFORMATION**

**PURPOSE OF DISCLOSURE:**

Release of Mental Health and AODA (Alcohol and Other Drug Addiction) and physical health information that will be used to plan and provide for the care, treatment and services for:

\_\_\_\_\_ (Youth's Name) \_\_\_\_\_ (Date of Birth)

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and/or the Mobile Urgent Treatment Team to release/exchange health related information including diagnosis, prognosis, treatment and planning related to the above named youth's enrollment in Wraparound Milwaukee to the appropriate staff at the State of Wisconsin/Title 19 Program that authorizes enrollment or provide emergency services for families enrolled in the Wraparound Milwaukee program.

Additionally, information as indicated below may be released to/received from the following:

**SHARED DOCUMENTS/INFORMATION**  
 (Check those that apply.)

	Demographic Information Only	Plan of Care	Referral for Services	Other * (See Below)
Milwaukee Public Schools/other school: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Families United of Milwaukee, Inc. (Family Advocate): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Physician: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Services Provider: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agency/Individual				
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agency/Individual				

\*Other Document/s: \_\_\_\_\_

**CONSENT FOR INFORMATION TO BE USED IN RESEARCH**

I give my consent for non-identifying evaluation data obtained during my enrollment in Wraparound to be used for research to evaluate the effectiveness of the program. I understand that this research may be presented at conferences, universities and in publications. I understand that information collected for this research is part of the usual Wraparound evaluation procedures. I understand that my family's confidentiality will be protected. No information that is presented to the public will contain any identifying information such as name, address or telephone number.

**EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION**

If not specified below, I understand that **this Authorization for Release of Information EXPIRES 12 MONTHS from the date it was signed.** I understand that **I may cancel this authorization at any time** (see back of sheet for instructions). This does not include any information that has been shared between the time I gave my consent to share information and the time that the consent was canceled.

This authorization expires on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

**REDISCLASURE NOTICE:** I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

\_\_\_\_\_  
 Parent or Legal Guardian Signature Date

\_\_\_\_\_  
 Youth Signature (age 14 and older should sign) Date

\_\_\_\_\_  
 Witness Signature Date

## **CLIENT RIGHTS RELATED TO AUTHORIZATION FOR RELEASE OF INFORMATION**

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**Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

**Failure to Sign** - I understand that failure to sign this authorization may severely limit the treatment / service options available for my child or family and/or may result in a request to the courts to modify the court order that allows for enrollment in the Wraparound Milwaukee program.

**Right to Withdraw This Authorization** - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Pamela Erdman, Wraparound Milwaukee Quality Assurance. (The statement must be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that Wraparound Milwaukee has made prior to receipt of my withdrawal statement

**Right to Inspect or Copy the Health Information to Be Used or Disclosed** - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department.

**HIV Test Results** - I understand my child's HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

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Wraparound Milwaukee Administrative Offices  
9201 Watertown Plank Road  
Milwaukee, WI 53226                      Phone: (414) 257-7608



WRAPAROUND MILWAUKEE  
**AUTHORIZATION FOR RELEASE  
 OF HEALTH INFORMATION**

(May be used following completion of Enrollment Packet Authorization Form)

**PURPOSE OF DISCLOSURE:**

Release of Mental Health, AODA (Alcohol and Other Drug Addiction) and physical health information that will be used to plan and provide for the care, treatment and services for:

\_\_\_\_\_ (Youth's Name) \_\_\_\_\_ (Date of Birth)

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and/or the Mobile Urgent Treatment Team to release/exchange health related information including diagnosis, prognosis, treatment and planning related to the above named youth's enrollment in Wraparound Milwaukee to the appropriate staff at the following agency/s:

AGENCY NAME / INDIVIDUAL NAME	SHARED DOCUMENTS/INFORMATION			
	(Check those that apply.)			
	Demographic Information Only	Plan of Care	Referral for Services	Other * (Specify Below)
Agency/Individual: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Identify Other Document/s: _____				
Agency/Individual: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Identify Other Document/s: _____				
Agency/Individual: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Identify Other Document/s: _____				
Agency/Individual: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Identify Other Document/s: _____				
Agency/Individual: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Identify Other Document/s: _____				

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**REDISCLASURE NOTICE:** I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

_____	_____
Parent or Guardian Signature	Date
_____	_____
Youth Signature	Date
_____	_____
Witness Signature	Date

## **CLIENT RIGHTS RELATED TO AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

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