CITY OF WATERTOWN DEPARTMENT OF HEALTH/FIRE/POLICE DEPARTMENT

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, the undersigned, hereby authorize the disclosure of the records and information specified below concerning _____

_____whose date(s) of birth is/are _____

by the City of Watertown Department of Health/Police/Fire Department (CWDHPFD) to:

Individual/Agency: _____

Address: _____

_____

TYPE OF INFORMATION TO BE RELEASED: **__x___** Verbal __x___ Written

INFORMATION TO BE RELEASED:

___ Intake/Initial Assessment ___* ___ Staffing/Progress Notes ___* ___ HIV (AIDS) ___*
___ Medical Evaluations/ H & P / Records ___* ___ Laboratory Reports ___* ___ Discharge Summary ___*
___ Social History ___* ___ Sexually Transmitted Disease ___* ___ Medications ___*
___ Treatment Plan/Reviews ___* ___ Education Evaluations/Records ___ *
___ Other (Specify): _____ ___*
* Denotes Items That Were Released

This information is to be released from the following CWDHPFD client/patient files/records at:

____ City of Watertown Department of Health, 515 S. First St., Watertown, WI 53094
____ City of Watertown Fire and Police Department, 106 Jones St., Watertown, WI 53094

For the Following Date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

___ Continuity and Coordination of Care ___ Insurance/Payment Concern ___ Medical Care
___ Educational Planning ___ Legal Investigation or Action ___ Personal

I understand that if the person and/or agency listed above are not governed by applicable federal and state laws and administrative codes, the confidential information disclosed as a result of this authorization may no longer be protected from further redisclosure without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

I understand that I have the right to inspect or have a copy of the confidential information I have authorized to be used or disclosed by this authorization form. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I am under no obligation to sign this form and that the person and/or agency listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization, I may contact my CWDHPFD staff providing/coordinating my services. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person and or agency listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the completion of active services with CWDHFD unless a specific date is entered here _____, or unless a written notice of revocation is submitted.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. A copy of this authorization will be considered as valid as the original

PRINT NAME: _____

SIGNATURE PATIENT/LEGAL REP: _____**DATE:** _____

Signature is that of the: _____ Client/Patient _____ Parent of Minor _____ Legal Guardian _____ Client/Patient's Representative

WITNESS: _____

EMERGENCY ALERT REQUEST FORM
PERSON SPECIFIC INFORMATION FOR FIRST RESPONDERS

Individual's Name (last name, first name, middle initial: _____

Date of Birth: _____

Address: _____
_____

County: _____

Current Physical Description:

Male_____ Female_____

Height _____ Weight _____ ***Attach Photo Here***

Eyes Color _____ Hair Color _____

Scars or any other Identifying marks (please describe):
_____
_____

Relevant Medical Conditions:

__Blind __Deaf __Non-Verbal __Physical Disability

__Developmental Disability __ Cognitively Disabled __Autism __Diabetes

__Mental Health Challenges __Prone to Seizures __Alzheimer's Disease

__Dementia __Acquired Brain Injury

__Other Relevant Medical Conditions, please explain: _____
_____
_____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact (Parents/Guardians, Head of Household/ Residence, or Care providers):
_____
_____

Emergency Contact's Address:
_____
_____

Emergency Contact's Phone Numbers:

Home: _____ Work: _____

Cell: _____ Pager: _____

TDD/TTY: _____
Name of Alternate Emergency Contact: _____

Home: _____ Work: _____

Cell: _____ Pager: _____

TDD/TTY: _____