DEPARTMENT OF HEALTH SERVICES
F-82009 (7/08)

STATE OF WISCONSIN
Sections 19.35 & 19.36, Wis. Stats.

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION GP (10/2025)

Completion of this form authorizes the release of information described in the section below called "Specific Description of Information for Release".

Name

Address

City, State, Zip Code

Identifying Number (If Any) | Date of Birth

Name & Address – **Agency/Organization I Authorize to Release Information**

Information May be Released To

Organization
University of Wisconsin-Population Health Institute

Address
610 Walnut Street

City, State, Zip Code
Madison, WI 53726

Specific Description of Information for Release

Government Performance and Results Modernization Act of 2010 (GPRAMA) data collected through this program.

Information May be Released To
Division of Care and Treatment Services

Organization
Wisconsin Department of Health Services

Address
201 E. Washington Ave.

City, State, Zip Code
Madison, WI 53703

Purpose or Need for Release of Information

This information is being collected as part of the State Opioid Response Grants implemented by the Wisconsin Department of Health Services (DHS) with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). The UW Population Health Institute is a partner with DHS on this project. The information collected through this program will provide key insight into the impact and progress of the program, and allow for an overall evaluation of these programmatic efforts. This program will operate from **9/30/2024 to 9/29/2027** or until the project ends. Providers offering services through this program will provide evidence-based treatment and services. Services may include a range of substance use related services such as, but not limited to, outpatient and residential-treatment, use of peer recovery support specialists, medication assisted treatment and naloxone, and other recovery support services.

For Verbal Consent: Explain the study to the potential subject verbally according to GPRAMA training protocol, providing all pertinent information (purpose, procedures, risks, benefits, alternatives to participation, etc.), and allow the potential participant ample opportunity to ask questions or voice concerns.

Understandings

- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:
  ☒ No exceptions ☐ Exceptions (specify):
- The information that I authorize to be released may be redisclosed by the recipient only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.
- I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release information.
- Unless revoked, this authorization will remain in effect until the expiration time indicated above.

Choose One:

☐ Authorization expires as of _____ (Date).

☐ Authorization expires _____ month(s) from the date I sign this authorization.

☒ Authorization expires after the following action takes place: Upon conclusion of this project.

As evidenced by my signature, I hereby authorize disclosure of Information to the person(s) or agency(s) specified above.

☐ Verbal consent was received by participant. Name of person receiving verbal consent:_____

Signature of person receiving verbal consent_____ Date consent received_____

SIGNATURE - Person Whose information Will be Released | Date Signed

SIGNATURE - Other Person Legally Authorized to Consent to Disclosure | Title or Relationship | Date Signed