DEPARTMENT OF HEALTH SERVICES
F-82009 (07/08)

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

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION V (02/2025)

Completion of this form authorizes the release of information described in the section below called "Specific Description of Records Authorized for Release". The person (record subject) whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication/somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances. Section 51.30, Wis. Stats., DHS 92.03-92.06 Wis. Adm. Code.

Name – **Person Whose Records Will be Released (Record Subject)**

Address

City, State, Zip Code

Identifying Number (If Any) | Date of Birth

Name & Address – **Agency/Organization I Authorize to Release Records**
WI Department of Children and Families
or
WI County Department of Human Services
or
equivalents in other states

Name - **Information May be Released To**
Rehabilitation Review Coordinator

Organization
Wisconsin Department of Health Services

Address
1 West Wilson Street

City, State, Zip Code
Madison, WI 53703

Email Address
dhsrehabreviewcoordinator@dhs.wisconsin.gov

Specific Description of Records Authorized for Release (Include dates of records, if applicable)
Child abuse/neglect substantiated and unsubstantiated findings and foster care records.

Purpose or Need for Release of Information (Be Specific)
I am applying for Rehabilitation Review as provided in ch. DHS 12, Wis. Admin. Code. Pursuant to Wis. Stat. § 50.065(2)(am), the department is required to determine whether I committed child abuse or neglect and to review that information to determine whether rehabilitation approval should be granted. This information will be included in my rehabilitation review file.

Understandings

- I make this authorization voluntarily as part of my application for Rehabilitation Review. Any released records will be included in my rehabilitation review file.
- The information that I authorize to be released may only be redisclosed by the Department 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 that was already released as a result of this authorization.
- Unless revoked, this authorization will remain in effect until your request for rehabilitation review has been processed and you have been issued a decision.
- By typing my name below and uploading this document to my electronic DHS Rehabilitation Review Application F-03331, I understand my typed name to have the same legal effect and enforceability as a manually executed signature.

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

SIGNATURE - Person Whose Records Will be Released (Record Subject) | Date Signed

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