DEPARTMENT OF HEALTH SERVICES
F-82009II (11/2017)

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

CONFIDENTIAL INFORMATION II RELEASE AUTHORIZATION

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 Information**

Department of Health Services
Division of Medicaid Services
Forward Health
313 Blettner Blvd.
Madison, WI 53784

Name - **Information May be Released To**
WIC Staff Workers

Organization

Address

City, State, Zip Code

Specific Description of Records Authorized for Release (Include dates of records, if applicable)

Information confirming whether the record subject (WIC applicant) is currently receiving Medicaid or BadgerCare Plus benefits.

Purpose or Need for Release of Information (Be Specific)

The Wisconsin WIC Program may access the Forward Health interchange Portal or Provider Services to review Wisconsin Medicaid Program or BadgerCare Plus member data. The purpose of this release is to simplify the application process for WIC benefits by allowing the WIC Program to find out whether the record subject (WIC applicant) is currently eligible for Medicaid or BadgerCare Plus and to review the medical status code assigned to the record subject (WIC applicant) for proof of income. Depending on the medical status code, the record subject (WIC applicant) may meet the requirement for proof of income. The Managed Care Organization name will be used to request Medicaid payment of a breast pump or for billing a blood lead test.

Understandings

- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:
  ☐ No exceptions ☒ Exceptions (specify**): If you decide not to sign this form, other proof of income will be needed to determine WIC eligibility and another source will be needed to obtain the Managed Care Organization name.**
- The information that I authorize to be released may be re-disclosed by the recipient of the records only if allowed by law. If information is re-disclosed, the recipient of the re-disclosed 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 below.

Choose One:

☐ Authorization expires as of (Date).

☒ Authorization expires **60** month(s) from the date I sign this authorization.

☐ Authorization expires after the following action takes place:

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

This institution is an equal opportunity provider