

**CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION**

<i>Individual Who Is Subject of Record:</i>	<i>Information May Be Released To:</i>
<b>Name:</b> _____	<b>Manitowoc County Sheriff's Office</b>
<b>Address:</b> _____	<b>Jail Health Services Unit</b>
<b>City, State, Zip Code:</b> _____	<b>1025 South 9<sup>th</sup> Street</b>
<b>Date of Birth:</b> _____	<b>Manitowoc, WI 54220</b>
<b>Identifying Number:</b> _____	<b>Telephone: (920) 683-4340 Fax: (920) 683-4405</b>

(Wisconsin Statutes Section 19.35 & 19.36 Federal Regulation 42 CFR Part 2)

***Name and Address of Agency or Organization Being Authorized to Release Information***

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***List Specific Records Authorized For Release (Include Dates of Records, if applicable)***

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**\*\*\*PURPOSE OR NEED FOR RELEASE OF INFORMATION IS CONTINUATION OF CARE\*\*\***

I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration time I have indicated by initialing below.

(Initial One and Complete if Necessary)

- \_\_\_\_\_ Authorization expires as of \_\_\_\_\_. (Date)
- \_\_\_\_\_ Authorization expires **12** months from the date I sign this authorization.
- \_\_\_\_\_ Authorization expires after the following action takes place: \_\_\_\_\_.
- \_\_\_\_\_ Authorization expires upon change in custody status.

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

**Signature of Individual Who is Subject of Record:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Other Person Legally Authorized to Consent to Disclosure:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Title or Relationship to Individual Who is Subject of Record:** \_\_\_\_\_