Permission to Obtain and Release Client Information/Records

Client Name: _____ **Date of Birth**: _____

I hereby authorize DeLand Receiving Home 824 Kentucky Avenue Sheboygan, WI 53081

_____[*insert name, agency, health care provider, name, address and telephone*] to release, exchange my child's information/records for the purpose listed below to:

_____[***insert name/title***]

_____[***insert name of agency***]

_____[***insertl address and telephone***]

Description:

The information to be disclosed consists of (dates and types of records):

_____ Medical and/or related health records
_____ Psychological, social work reports
_____ School cumulative and /or behavioral records
_____ Others (Specify) _____

Purpose:

This information will be used for the following purpose(s):

1. _____
2. _____
3. _____

Authorization:

This authorization is valid for one calendar year. It will expire on _____[*insert date*]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information.

_____ /_____
Parent(s)/Guardian(s) Signature Date

_____ /_____
Student Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Wisconsin, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for HIV/AIDS, and family planning services.

Photocopy valid as original
Copies: Parent(s)/Guardian(s) or student*
Physician or other health care provider releasing the protected health information/records
School official requesting/receiving the protected health information/records