Reach Dane
Head Start
Early Head Start
Child Care

Label Here
Child's Name _____
Program _____
PY _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
Verbal Communication and/or Copies of Records

1. Patient Information

Name – Last, First, MI		Date of Birth
Street Address		
City	State	Zip Code

AUTHORIZES: ☒ Release of information to: or ☒ Exchange of information with: (must select one or both)

_____
Name of Health Care Provider, Clinic, Plan/Other

_____
Street Address

_____
City State Zip Code

REACH DANE
HEAD START – EARLY HEAD START – CHILD CARE
2096 RED ARROW TRAIL
FITCHBURG, WI 53711
PHONE: 608-275-6740 FAX: 608-275-6756

DISCLOSURE OF MEDICAL RECORD COPIES

Information to be disclosed:	Date of Service	Information to be disclosed:	Date of Service
☐ Physical Exams/History	_____	☐ Consultations	_____
☐ Immunization/LEAD screens	_____	☐ Discharge Summary	_____
☐ PT/SP/OT	_____	☐ Labs - EKG/EEG/EMG	_____
☐ Operation/Procedure Report	_____	☐ Dental Exam/Treatment	_____
☐ Mental Health/Psychology/Neuropsychology: _____		☐ Other: _____	_____

VERBAL COMMUNICATION

☐ Communication between those listed in Section 2 (includes any information unless limited below), or
☐ Limited communication (specified): _____

PURPOSE OF DISCLOSURE:

☒ Required for enrollment in group childcare ☒ Further medical care
☒ Coordination of health services ☐ Other: _____

EXPIRATION DATE: This authorization will remain in effect until the following date(s) _____ or for one year from the date signed. Note: This authorization will apply to medical information generated during the extended time period.

RE-RELEASE: I understand the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient and/or no longer protected by Federal Privacy standards.

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

- **Right to Receive Copy of this Authorization**: I understand that if I agree to sign this authorization, I will receive a copy of it.
- **Right to Inspect or Copy the Health Information to be Used or Disclosed**: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed per this authorization.
- **Wisconsin Right to Privacy:** Under Wisconsin law, you have the right to be free from unreasonable invasions of privacy. Wisconsin's "Right of Privacy" statute prevents individuals from using your name, portrait, or picture for advertising or trade purposes without first obtaining your written authorization.
- **No Obligation to Sign:** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefit on my decision to sign this authorization.
- **Revocation:** I have the right to revoke this authorization by notifying the Health Manager in writing of my desire to revoke it. However, I understand that any action already taken in reliance to this authorization, cannot be reversed and my revocation will not affect those actions.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes for the minor child listed above.

Print Name_____ Date: _____

Signature_____ Authority to sign: ☐ Parent ☐ Guardian