Reach Dane
Head Start
Early Head Start
Child Care

Label Here
Child's Name _____
Program _____
PY _____

Consent for Health Services Release
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. Patient Information

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

AUTHORIZES:

Wisconsin Childhood Lead Poisoning Prevention Program
Name of Health Care Provider, Clinic, Plan/Other

1 West Wilson Street
Street Address

Madison Wisconsin 53703
City State Zip Code

RELEASE OF PROTECTED HEALTH INFORMATION TO:

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

Information to be released:	Date of Service	Information to be released:	Date of Service
☐ Physical Exams/History	_____	☐ Consultations	_____
☐ Immunization/LEAD screens	_____	☐ Discharge Summary	_____
☐ PT/SP/OT	_____	☐ Labs - EKG/EEG/EMG	_____
☐ Operation/Procedure Report	_____	X Other: All Lead Test Results	All
☐ Dental Exam/Treatment	_____		

This disclosure is being made for the following reason(s):

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

REDISCLOSURE NOTICE: 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.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

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 by the authorization form.

Right to Receive Copy of This Authorization – I understand that if I agree to sign this authorization, I will be provided with a copy of it.

Right to Refuse to Sign This Authorization – I understand 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 benefits on my decision to sign this authorization.

I may revoke this authorization by notifying Child Health/Development Dir *or* _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for one year from the date signed. I understand that I am authorizing the release of medical records generated prior to the date of signature, as well as those records generated in the future prior to the expiration of this authorization.

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.

Patient is a Minor Signature of Legal Representative *(must be legible)*: _____

Authority to sign ☐ Parent ☐ Guardian Date: _____

White – Master File