CONFIDENTIAL INFORMATION 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.

Person Whose Records Will Be Released (Record Subject) **(child)**

Name	Identifying Number (If Any)	Date of Birth

Address (Street address or PO Box, City, State, Zip Code)

Agency / Organization I Authorize to Release Information

Name
DANE COUNTY HUMAN SERVICES

Address (Street address or PO Box, City, State, Zip Code)
1819 Aberg Ave, Madison, WI 53704

Information May Be Released To

Name	Organization
	Dane County Parent Council-Reach Dane

Address (Street address or PO Box, City, State, Zip Code)
2096 Red Arrow Trl, Fitchburg, WI 53711

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

All records are pertinent to the Reach Dane program participants the information that can be shared between the agencies is:

1. Case status
2. Approved activity for parent or caretaker
3. Information that would help the parent/caretaker to secure Wisconsin Share benefits.
4. Any other pertinent information that would help to expedite the Wisconsin Shares eligibility--please explain in detail.
5. Work schedule
6. Information relevant to current FoodShare benefit.

Purpose Or Need for Release of Information (Be Specific)

The purpose for this release of information is for the coordination of benefits between customers who are enrolled in the Reach Dane program and the Wisconsin Shares Agency.

The Wisconsin Shares policy prevents us from disclosing the Wisconsin Shares EBT card number, actual amount of subsidy and the hours approved.

Understandings

This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:

- ☒ No exceptions
- ☐ Exceptions (specify):

The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed 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 12 month(s) from the date I sign this authorization.
- ☐ Authorization expires after the following action takes place (specify):

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.	
Person Whose Records Will be Released (Record Subject)	
SIGNATURE	Date Signed
Other Person Legally Authorized to Consent to Disclosure	
SIGNATURE	Date Signed
Title or Relationship to Record Subject	