**AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION**

The intent of this disclosure is to authorize the release and exchange of information for the purpose of Positive Alternatives providing the proper care and service to the client. This form shall not be used to re-release information provided to Positive Alternatives by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am the parent(s) or guardian(s) of (*name of information to be released*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (DOB) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I hereby consent to authorize the written (email, report) and verbal exchange of information regarding the psychological evaluation, social history, AODA assessment, family assessments, neurological assessments, court services summary, school records, IEP records, if applicable, etc. as it pertains to the care and service the client is receiving. I consent for Positive Alternatives, Inc. to provide and receive such information as needed with the following agencies:

**\_\_All Apply**

\_\_Positive Alternatives, Inc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Northwest Journey

\_ Mikan Day Treatment (Previous School)

\_\_Marshfield Clinic Health Systems

\_ Aspirus Health Care

\_\_Riverview Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Aspirus Clinic, Inc.

\_Mountain Bay Dental (Therapist)

\_\_Daly Drug

\_ Daly Drug Long Term Care

\_ ADRC

\_ ODC \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Shopko Optical

\_ Walmart Vision Center (Psychiatrist/Family Doctor)

\_\_WI Rapids School District

\_ Wood County Alternative School

\_\_WI Rapids Police Dept. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Wood County Sheriff Dept.

\_ MTM Transportation (Other)

\_\_Riverview Community Dental Clinic

\_ Marshfield Clinic Dental Services

\_ Wood County Crisis

\_ Department of Vocational Rehabilitation

\_\_Wood County Dept. of Human Services

\_ Stoiber Chiropractic Care

\_ UWSP Upward Bound

\_ Cook Family Chiropractic Care

\_ Compass Counseling

\_ Central Wisconsin Counseling Associates

\_ Youth For Christ

\_ Northcenteral Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Other)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Other)

\**Other may include relative, attorney, GAL, etc.*

I hereby consent to authorize the release of information developed by Positive Alternatives which includes treatment assessments, treatment plans, progress reports, service notes, observation notes, incident reports, etc. with the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department of Human/Social Services

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other

I understand that under extraordinary circumstances, including but not limited to, such as emergencies requiring law enforcement or medical emergencies, confidential client information may be shared without prior consent. The information shared must be pertinent to the situation at hand.

I understand I have the right to refuse to sign this form. I may also revoke my consent at any time (except to the extent that the information has already been released)This consent will take effect the day of signature and will automatically expire 30 days following discharge from the program or exactly one (1) year from the date it is signed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date Client Signature Date