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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-01238 (05/2014) | | | | **STATE OF WISCONSIN** | | | | | | | |
| **CONSENT TO RELEASE MEDICAL INFORMATION**  **REFERRAL TO A REGIONAL CENTER FOR CHILDREN AND YOUTH**  **Northern CYSHCN Center fax 715-261-1901 phone 866-640-4106**  **Northeast CYSHCN Center fax 920-969-7975 phone 877-568-5205**  **Southern CYSHCN Center fax 608-265-3441 phone 800-532-3321**  **Southeast CYSHN Center fax 414-266-2225 phone 800-234-5437**  **Western CYSHCN Center fax 715-726-7910 phone 800-400-3678**  ***\*****See page 2 for a list of counties served by each Regional Center.*  **WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)**  **(\*See page 2 for list of Counties served by each Regional Center)** | | | | | | | | | | | |
| **CHILD - Demographic Information** | | | | | | | | | | | |
| Child’s Full Name (First, MI, Last) | | | | | Date of Birth (mm/dd/yyyy)     /    / | | | | | | Gender  M  F |
| Home Address | City | | | | County of Child’s Residence | | | | | | Zip Code |
| Parent/Guardian Name | | | | | | | | | | Primary Language Spoken | |
| Email Address | | | Primary Telephone No.  (     ) | | | Other Telephone No.  (     ) | | | | | |
|  | | | | | | | | | | | |
| **Provider - reason for referral** *(Check all that apply)* | | | | | | | | | | | |
| Respite care  Transition to adult care  Health benefits counseling  Family education/advocacy  Transportation/meals/lodging for health care  Special foods/formulas  Education-related services  Connection to Birth to 3 or Early Childhood Special Education  Parent to Parent support  Access to community resources (i.e., pediatric therapies, family support programs, summer camps)  Parent concern (please specify)  Special equipment (please specify)  Information (please specify topic)  Other: | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Provider - contact information** | | | | | | | | | | | |
| Medical Clinic | | | | | Primary Provider - Name | | | | | | |
| Address | | City | | | | | | State | | | Zip Code |
| Email Address | | | Office Telephone No.  (     ) | | | Office Fax  (     ) | | | | | |
| Diagnosis or special need of child if known | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **REGIONAL CYSHCN CENTER REFERRAL RESPONSE** *(Check one)* | | | | | | | | | | | |
| Family contacted and services provided  Unable to contact family (reason):  Family contacted and services declined  Other comments: | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Parents - consent for release of inFOrmation** | | | | | | | | | | | |
| **I authorize the referring provider to disclose the information needed and indicated on this form to the Regional Center for Children and Youth with Special Health Care Needs to assist the Regional Center staff in accessing services and identifying resources for my child and family. By signing this form I:**   * give permission for the providers listed above to share this information for the purposes of accessing services. * can cancel this consent in writing at any time except for information already released as a result of this authorization. The written revocation must be given to the organization authorized to release the information. * understand consent will end 1 year from the date I sign it. * have the right to inspect, and upon paying applicable fees, obtain a copy of the disclosed records. * understand the information I have authorized to be released may be redisclosed by the recipient of these records only if allowed by law. If information is disclosed, the recipient of the redisclosed information may be controlled by different laws. * am not required to sign this authorization, it will not put my relationship with my child’s health care provider at risk. | | | | | | | | | | | |
| **SIGNATURE** -**\*\*Parent/Guardian** | | | | | | | | | Date Signed | | |
| Print Name of Parent/Guardian | | | | | | | Indicate legal authority of person signing  Parent of Minor  Legal Guardian | | | | |
| \*\*If Parent/Guardian contact information is different from the child listed on this form, please provide a cell phone number and/or  email address: Cell phone:       Email Address: | | | | | | | | | | | |

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| **\*Regional Centers and Counties served by each center:**  **Northern Regional Center** fax (715) 261-1901 telephone (866) 640-4106  *Ashland ▪ Bayfield ▪ Florence ▪ Forest ▪ Iron ▪ Langlade ▪ Lincoln ▪ Marathon ▪ Oneida ▪ Portage Price ▪ Sawyer ▪ Taylor ▪ Vilas ▪ Wood*  **Northeast Regional Center** fax 920-967-1001 telephone (877) 568-5205  *Brown ▪ Calumet ▪ Door ▪ Fond du Lac ▪ Green Lake ▪ Kewaunee ▪ Manitowoc ▪ Marinette*  *Marquette ▪ Menominee ▪ Oconto ▪ Outagamie ▪ Shawano ▪ Sheboygan ▪ Waupaca ▪ Waushara ▪ Winnebago*  **Southern Regional Center** fax (608) 265-3441 telephone (800) 532-3321  *Adams ▪ Columbia ▪ Crawford ▪ Dane ▪ Dodge ▪ Grant ▪ Green ▪ Iowa ▪ Juneau ▪ Lafayette*  *Richland ▪ Rock ▪ Sauk ▪ Vernon*  **Southeast Regional Center** fax (414) 266-2225 telephone (800) 234-5437  *Jefferson ▪ Kenosha ▪ Milwaukee ▪ Ozaukee ▪ Racine ▪ Walworth ▪ Washington ▪ Waukesha Counties*  **Western Regional Center** fax (715) 726-7910 telephone (800) 400-3678  *Barron ▪ Buffalo ▪ Burnett ▪ Chippewa ▪ Clark ▪ Douglas ▪ Dunn ▪ Eau Claire ▪ Jackson ▪ La Crosse Monroe ▪ Pepin ▪ Pierce ▪ Polk ▪ Rusk ▪ St. Croix ▪ Trempealeau ▪ Washburn*  Map of Wisconsin Counties, with links to contact information about local health departments | |