Camp Wediko

Authorization to Release Information

Child's Name: _____ Date of Birth: _____

Child's Address: _____

Information to be Released/Obtained

This authorization allows Wediko Children's Services and another entity to exchange information that will assist in providing clinical services to the client identified above. Information to be released/obtained about the client's treatment may include sensitive medical and personal information. The types of information to be exchanged includes but is not limited to: mental health treatment records, academic information, information about medical conditions and care, psychiatric evaluations, treatment summaries and other information shared verbally that is pertinent to the clinical services provided by Wediko Children's Services. If authorizing the release of HIV-related, sexual assault related, or alcohol and drug treatment related information, the recipient is prohibited from the re-disclosure such information without authorization unless permitted to do so under federal or state law. To better understand about the information being released or obtained, speak to your therapist and/or health administrator.

□ Medical records from the following dates: _____ to _____

□ Evaluations □ Other: _____

□ Included (Please indicate with initials):

_____ HIV related information _____ Sexual assault treatment _____ Alcohol/Drug treatment

Provider/Agency: _____ Phone: _____

Provider/Agency Address: _____

Revocation and Time Limit

I understand that signing this authorization is voluntary. I can change my decision and have this authorization revoked at any time with a request to Wediko Children's Services. I understand that I may revoke this authorization, however the materials that have already been released to Wediko Children's Services or other agencies under the authorization will be valid for use. This authorization is valid for one year after the date signed, unless a cancellation request is submitted. Information disclosed under this authorization may be re-disclosed by the recipient, and that such re-disclosure is no longer protected by federal or state law. I authorize Wediko Children's Services and the above-named agency/provider to release/obtain information pertinent to the client's care and treatment. I agree to release Wediko Children's Services, its officers, directors, employees and associated professionals, clinicians, and therapists from any liability that arise from the release of this information to any individual or agency/provider listed above.

_____ _____

Name of Parent/Guardian/Agency Representative | Relationship to client

_____ _____

Signature of Parent/Guardian/Agency Representative | Date

Updated: 01/14/19

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