

## CONSENT TO RELEASE MEDICAL INFORMATION REFERRAL TO A REGIONAL CENTER FOR CHILDREN AND YOUTH 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)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Street Address	City	State	County of Child's Residence	Zip Code	
Parent/Guardian Name			Primary Language Spoken		
Email Address	Primary Phone Number		Other Phone Number		

### 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			
Street 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: \_\_\_\_\_

**\*Contact Information for Regional Centers and Counties served by each center:**

**Northern Regional Center**

Email [specialneedsinfo@co.marathon.wi.us](mailto:specialneedsinfo@co.marathon.wi.us)

Fax (715) 261-1901

Telephone (866) 640-4106

**Northeast Regional Center**

Email [infonerc@chw.org](mailto:infonerc@chw.org)

Fax 920-967-1001

Telephone (877) 568-5205

**Southern Regional Center**

Email [serc@chw.org](mailto:serc@chw.org)

Fax (608) 265-3441

Telephone (800) 532-3321

**Southeast Regional Center**

Email [serc@chw.org](mailto:serc@chw.org)

Fax (414) 266-2225

Telephone (800) 234-5437

**Western Regional Center**

Email [wrcyshcn@co.chippewa.wi.us](mailto:wrcyshcn@co.chippewa.wi.us)

Fax (715) 726-7910

Telephone (800) 400-3678

