

## Consent to Release Medical Information Referral to a Children's Resource Center for Children and Youth with Special Health Care Needs (CYSHCN)

(\*See page 2 for list of Counties served by each Resource 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)

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Respite care   | <input type="checkbox"/> Transition to adult care | <input type="checkbox"/> Health benefits counseling | <input type="checkbox"/> Family education/advocacy |
| <input type="checkbox"/> Transportation/meals/lodging for health care   | <input type="checkbox"/> Special foods/formulas   | <input type="checkbox"/> Education-related services |  |
| <input type="checkbox"/> Connection to Birth to 3 or Early Childhood Special Education                                    | <input type="checkbox"/> Parent to Parent support |   |  |
| <input type="checkbox"/> Access to community resources (i.e., pediatric therapies, family support programs, summer camps) |   |   |  |
| <input type="checkbox"/> Parent concern (please specify):   |   |   |  |
| <input type="checkbox"/> Special equipment (please specify):  |   |   |  |
| <input type="checkbox"/> Information (please specify topic):  |   |   |  |
| <input type="checkbox"/> Other:   |   |   |  |

### Provider – Contact information

Medical clinic		Primary provider name	
Street address	City	State	ZIP code
Email address	Office phone number	Office fax	
Diagnosis or special need of child, if known			

### Children's Resource Center referral response (Check one)

- |   |   |
|---|---|
| <input type="checkbox"/> Family contacted and services provided | <input type="checkbox"/> Unable to contact family (reason): |
| <input type="checkbox"/> Family contacted and services declined | <input type="checkbox"/> 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 Children's Resource Center to assist the Resource 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:**

email address:	Cell phone:	Email address:
----------------	-------------	----------------

**\*Contact information for Resource Centers and Counties served by each center:**

**Children's Resource Center – North**

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

Fax: 715-261-1901

Phone: 866-640-4106

**Children's Resource Center – Northeast**

Email: [crcnortheast@childrenswi.org](mailto:crcnortheast@childrenswi.org)

Fax: 920-967-1001

Phone: 877-568-5205

**Children's Resource Center – South**

Email: [crcsouth@waisman.wisc.edu](mailto:crcsouth@waisman.wisc.edu)

Fax: 608-729-4133

Phone: 800-532-3321

**Children's Resource Center – Southeast**

Email: [crcsoutheast@childrenswi.org](mailto:crcsoutheast@childrenswi.org)

Fax: 414-266-2225

Phone: 800-234-5437

**Children's Resource Center – West**

Email: [crcwest@chippewacountywi.gov](mailto:crcwest@chippewacountywi.gov)

Fax: 715-726-7910

Phone: 800-400-3678

