YWCA ROCK COUNTY
AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

Milton Families

Child's Name: _____ Date of Birth: _____ School_____

INSTRUCTIONS: Complete the Authorization Statements below, place checkmarks by the information that may be disclosed and sign the authorization. In order to allow the exchange of information between the YWCA Child Care Program and the **School District of Milton**, please check both of the Authorization Statements below.

AUTHORIZATION STATEMENTS:

_____I, the undersigned, hereby authorize the YWCA Child Care Program to disclose by any means (including written, oral, or electronic means) the information indicated below regarding the pupil to the School District of Milton 448 East High St. Milton, WI. 53563

_____I, the undersigned, hereby authorize the School District of Milton to disclose by any means (including written, oral, or electronic means) the information indicated below regarding the pupil to the YWCA Child Care Program 1735 S. Washington St. Janesville, WI. 53546

INFORMATION TO BE DISCLOSED:

Education & Health Information/Records

- Behavioral Records/Plans
- Special Education Records (IEPs, 504 plans, etc)
- Developmental Disabilites
- Physical Health Records
- Patient Health Information (medications, diagnoses, etc)
- Other (specify) _____
  _____

- PURPOSE OF DISCLOSURE: The information is requested for the purpose of education programming, planning and service or other (please specify) _____

ACKNOWLEDGEMENTS: **Receive Records & Authorization-** I understand that I have a right to a copy of the records that are disclosed and a right to a copy of this authorization. **Withdrawal of Authorization**- I understand that I have a right to revoke this authorization, except to the extent that disclosure has already been made in reliance of this authorization. I understand that my revocation is effective only if it is in writing and it is submitted to the individual/entity that is releasing information. **Re-Disclosure of Health Information-** I understand that if my child's health information is released pursuant to this authorization, it may be subject to re-disclosure by a person who receives the health information and may not be protected by law.

This permission is valid for one year from the date signed. A copy of this form is as effective as the original. I agree to have records release that were developed after the date of signature, but fall within the year limitation. I certify that I am the parent, legal guardian, personal representative of the child named above.

Signature _____ Date_____

Print Name _____ Relationship to Child _____

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