Social Service Release of Information

PACT for West Central Illinois, PACT for West Central Illinois, 2090 Highway 24, Camp Point, IL 62320
(ph# 217-773-3903, fax# 217-773-3906)

Child's Name: _____

Parent/Guardian: _____

Address: _____

I hereby authorize Parent & Child Together (PACT) for West Central Illinois to release/receive the following confidential information regarding the above named individual to/from:

_____
(agency or person's name)

_____
(address)

_____
(town and state)

for the purpose of:

❒ **Obtaining a copy of family service plan** ❒ Scheduling medical/dental appointments

❒ Obtaining services ❒ Sharing/coordinating educational information

❒ Other _____

I understand that this release is voluntary and will allow for two-way conversation between the provider(s) and PACT personnel concerning planning, goal setting, etc.
I understand that I may revoke this authorization by giving written notice. However, revoking this release will not have effect on actions taken by providers to whom the release was sent before revocation.
I understand that the information used or disclosed can be subject to re-disclosure by the agency receiving it and is not protected by the federal privacy regulations. However, PACT does not re-disclose information unless a written authorization is requested and signed by the parent(s).
I understand that this authorization is valid for one year from the date signed, or until I revoke it in writing to the agency releasing information.

Signature: _____ Date: _____