AUTHORIZATION FOR RELEASE OF Medical Plan

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

I, the parent/guardian of named child, hereby authorize named health provider to **complete the attached form and release it to PACT for West Central Illinois for the purpose of treatment of my child's health concerns while at PACT's classroom.**

☐ **Asthma Action Plan**
☐ **Emergency Plan ________________**
☐ **Dietary Information ______________**

My child attends class _____ days a week, from (time) ______ to (time) _______.
My child rides a bus to and from school. ☐ Yes ☐ No

Child Name ____ DOB ___/___/___
Parent/Guardian name ____
Street Address ____
City, State, Zip ____

Information to be released from:

Health Provider ____
Street Address____
City, State, Zip____
Phone # ______________________ Fax # ________________________

I understand that I may revoke this authorization by giving written notice. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by the provider in reliance before I revoked it. I understand that the information used or disclosed may be subject to re-disclosure by the agency receiving it and is no longer protected by the federal privacy regulations. However, PACT does not re-disclose information unless a written authorization requests it. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits from the provider releasing information (listed above). I understand that this authorization is valid one year from the date signed, or until I revoke it in writing to the agency releasing information.

____ ____________________
(Parent or DCFS Authorized Agent Signature) (Date)

Send requested information to:

PACT for West Central Illinois
2090 HWY 24
Camp Point, Illinois 62320
FAX # 217-773-3906

(The child will not be able to attend class until the plan and any needed medication is on file at our center)

This release is filled out with parent by Family Advocate during Intake Visit. Forward completed form to Site Supervisor for mailing to provider. If the child is in foster care, forward to the Authorized Agent for the signature.