Vision Forward Association

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I, _____, hereby authorize the disclosure and exchange of the specific information listed in this document between:

Vision Forward Association
912 N. Hawley Road
Milwaukee, WI 53213

AND
Name: CLTS
Address: _____
_____

[Describe the information to be used or disclosed, including, but not limited to, descriptors such as date of service provided, level of detail to be released, origin of information, etc.]

Oral and written communication including medical records

This protected health information is being used or disclosed for the following purposes:

Coordinate a special education program and therapy services

This authorization shall be in force and effect for **12 months from the date of signature** at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by completing the "Revocation of Consent or Authorization to Release PHI Form" from the office manager, and sending such written notification to Vision Forward Association at 912 N. Hawley Road, Milwaukee, WI 53213. I understand that a revocation is not effective to the extent that Vision Forward Association has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal or state law.

Vision Forward Association will not condition my treatment, payment, or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

[The use or disclosure requested under this authorization may result in direct or indirect remuneration to Vision Forward Association from a third party]

Signature of parent _____ Date _____

Name of child _____ DOB _____