Confidential Information Release and Discussion Authorization

Completion of this form authorizes (check all that apply):

The release of information detailed in the section below titled “Specific Description of Records Authorized for Release”, which is information about the person (Subject) whose records will be released and collected in the Wisconsin Refugee Programs Database (WRPD) and/or using another DCF form(s).

The release of information about the eligibility or specific services provided to the Subject, for the purpose of allowing a proxy, such as a sponsor, relative or other third party, to discuss details of the Subject’s case with the Agency/Organization listed below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Person (Subject) Whose Records Will Be Released/Case Details Will Be Discussed** | | | |
| Name | | Date of Birth | |
| Address (Street address or PO Box, City, State, Zip Code) | | | |
| **Agency / Organization Authorized to Release Information (e.g., BRP-funded agency, relative, sponsor)** | | | |
| Name | | | |
| Address (Street address or PO Box, City, State, Zip Code) | | | |
| **Information May Be Released To (e.g., BRP-funded agency, relative, sponsor)** | | | |
| Name | Agency/Organization (if applicable) | | |
| Address (Street address or PO Box, City, State, Zip Code) | | | |
| **Specific Description of Records Authorized for Release** **(e.g., any, WRPD records**) | | | |
| **Purpose Or Need for the Release of Information** **(e.g., to help the Subject obtain employment)** | | | |
| **Limitations or Exceptions to the Release of Information** **(e.g., health records)** | | | |
| **Understandings** | | | |
| The information that I authorize to be released may be disclosed again by the recipient of the records only if allowed by law. If information is disclosed additional times, the recipient(s) of this information may be controlled by different laws. | | | |
| I may revoke this authorization, in writing, at any time; however, this will not include information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release the information. | | | |
| Unless revoked, this authorization will remain in effect until the expiration time indicated below.  **Choose One:**  Authorization expires as of       (Date).  Authorization expires after the following action takes place (specify):  Authorization does not expire | | | |
| **As evidenced by my signature, I hereby authorize disclosure of records to and/or the details of my case to be discussed with the person(s) or agency(s) specified above.** | | | |
| **Person (Subject) Whose Records Will be Released / Case Details Will Be Discussed** | | | |
| SIGNATURE | | | Date Signed |
| **Other Person Legally Authorized to Consent to Disclosure** | | | |
| Title or Relationship to Subject | | | |
| SIGNATURE | | | Date Signed |