CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

Completion of this form authorizes the release of information described in the section below called "Specific Description of Records Authorized for Release." The person (record subject) whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication / somatic treatment records, a director / designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances. Section 51.30, Wis. Stats., DHS 92.03-92.06 Wis. Adm. Code.

Person Whose Records Will Be Released (Record Subject)

Name	Identifying Number (If Any)	Date of Birth

Address (Street address or PO Box, City, State, Zip Code)

Agency / Organization I Authorize to Release Information

Name
Madison Accreditation Program

Address (Street address or PO Box, City, State, Zip Code)
215 Martin Luther King Jr. Blvd., Room 225

Information May Be Released To

Name	Organization

Address (Street address or PO Box, City, State, Zip Code)

Specific Description of Records Authorized for Release (Include dates of records, if applicable)
All relevant information and records relating to child and family's experience in the child care program, retroactive to the date of enrollment in the program.

Purpose Or Need for Release of Information (Be Specific)
This child care program is Madison Accretited. The accredidation process involves observation, feedback by the child care accreditation specialists, and consultation with the child care center staff. The consultation is focused on quality improvement, support for the well-being of children, and the excellence of the program. This release ensures that the center is in compliance with State Licensing rule 251.04 (7) regarding the release of confidential information.

Understandings

This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:

☐ No exceptions
☒ Exceptions (specify): Accreditation staff will observe and may discuss programming for individual children and families with center staff. Discussions between accreditation staff and center staff will follow strict confidentiality principles.

The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.

I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency / organization I authorized to release information.

Unless revoked, this authorization will remain in effect until the expiration time indicated below.

Choose One:

☐ Authorization expires as of (Date).
☐ Authorization expires month(s) from the date I sign this authorization.
☒ Authorization expires after the following action takes place (specify): Parent revokes authorization.

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

Person Whose Records Will be Released (Record Subject)

SIGNATURE	Date Signed

Other Person Legally Authorized to Consent to Disclosure

SIGNATURE	Date Signed
Title or Relationship to Record Subject	