RSI
Responsive Solutions, Inc.

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

**Authorized Agent/Organization**
**Responsive Solutions, Inc.**
**122 E. Olin Ave., Suite 100**
**Madison, WI 53713**

**Regarding Records Of:**
**Name: _____**
**Address: _____**
**_____**
**Date of Birth: _____**
**Soc. Sec. #: _____**

**I Authorize Responsive Solutions, Inc. to disclose and receive information and records to and/or from the following persons/organization/agencies:**

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**The information requested from my records includes:**
**Any medical or other records needed by the above organizations**

**The purpose of the need for such disclosure is:**
**To gain information regarding: _____**
**_____**

**Disclosure under this release includes access to records, permission to obtain copies of records, and oral discussion of information between agency staff and individual service providers.**

**I understand that this consent to disclose may be revoked by me in writing at any time except that information already released with my consent may continue to be used to complete actions already taken. This consent expires one year from the date of signature, unless expressly revoked earlier. A photocopy of this authorization has the same effect as the original.**

_____
**Signature of Program Participant** **Date**

_____
**Signature of Guardian** **Relationship**

_____
**Signature of Witness**



FAMILY, INDIVIDUAL AND COMMUNITY STRENGTH
DANE COUNTY
DEPARTMENT OF HUMAN SERVICES