



Fond du Lac Area YScreen Program

72 W. Ninth Street, Fond du Lac, WI 54935
(Phone) 920-906-6571 or 920-906-6777 (Fax) 920-906-6563

INFORMED CONSENT TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

1. Regarding Student:

Last Name		First	
Date of Birth		Telephone	
Address	City	State	Zip

2. Release From Fond du Lac Area YScreen

72 W. 9th Avenue Fond du Lac, WI 54935

Address	City	State	Zip
---------	------	-------	-----

Attention: YScreen Case Manager

Release To: _____

Name of Business (Counseling Center, Hospital, Clinic, Etc.)

Address	City	State	Zip
---------	------	-------	-----

Attention: _____

3. Information to be released: ☒ YScreen Results ☒ Clinical Interview ☒ Symptom Checklist for school
In the form of ☒ Verbal ☒ Photocopies
4. This consent expires one year from the date of signature.

Student/Parent Rights (please read before signing): You may request multiple releases of information identified on this authorization form. You may receive a copy of this authorization. The YScreen Program does not condition treatment, or eligibility for benefits based on the signing of this authorization. You may revoke this authorization at any time (except to the extent that the YScreen Program has already acted in reliance upon it), by written notice to the Fond du Lac Area YScreen Program. Attention: Privacy Officer. If the person or organization requesting this information is not subject to the federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards. A photocopy of this authorization shall be as valid as the original.

I hereby release the Fond du Lac Area YScreen Program from any liability that may arise out of this disclosure.

Student Signature	Date
-------------------	------

Parent/Legal Guardian Signature (if student is under 18)	Date
----------------------------------------------------------	------

Witness	Date
---------	------