DISCLOSURE AUTHORIZATION

FOR CHILD NAMED: ____

This referral is a recommendation for the child and parent/legal guardian to participate in the Straight Talk Education Program held at the University of Michigan Hospital.

AGENCY CONTACT INFORMATION

Agency/Department/School/Court name: ____

City: ____ State: ____________________

HOSPITAL CONTACT INFORMATION

University of Michigan Hospital UH 1C435 1500 East Medical Center Dr. Ann Arbor, MI 48109-5033	**Karla Klas, RN, BSN, CCRP** Managing Director, Injury Prevention and Community Outreach Straight Talk Program Coordinator Phone: **(734) 232-3815** FAX: **(734) 232-3833** E-mail: kahrns@med.umich.edu	**Kristy Brown** Phone: **(734) 232-3814** FAX: **(734) 232-3833** E-mail: kribro@med.umich.edu

DISCLOSURE AUTHORIZATION

I, ____________________________________ (Parent/Legal Guardian) hereby authorize above named Agency/School/Department/Court, its director or designee, to release information to the above named hospital and Straight Talk Program Coordinators regarding said named child. The intent and nature of this information will concern my child's attendance, progress, services received and recommendations for additional services when deemed necessary. The purpose of this disclosure is to allow the above named agencies and persons to exchange information.

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Signature of Parent/Legal Guardian   Date

Rev. 11-26-2012