MADISON AREA REHABILITATION CENTERS, INC.

Exchange of Information

I (name of person receiving services), _____

or my legal guardian, give permission to: _____
(Agency/School/Vendor)

Agency/School/Vendor _____

_____

To give and receive information identified below with/from Madison Area Rehabilitation Centers, Inc. in writing, verbally, fax, and or electronic mail, for the purpose of assisting them in planning, providing, and monitoring their services to me. Information that may be shared pertains to my:

_____ DVR plan, assessment, funding and/or eligibility information
_____ Behavioral Information
_____ Education and Training
_____ Income
_____ Independent Living Skills
_____ Medical Diagnosis, treatment, & surgical procedures
_____ Medications
_____ Psychological Information
_____ Therapies (OT, PT, Speech)
_____ Vocational /Employment Skills
_____ other _____

This consent is effective for the entire time services are received from MARC, Inc., unless changed by participant or legal guardian.

IMPORTANT PLEASE NOTE:
I understand that I, or my legal guardian, may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

_____ _____
Client Signature Date

_____ _____
Guardian Signature (if applicable) Date

MARC RES/RAC & South
901 Post Road
Madison, WI 53713
p. 608-223-9110
f. 608-223-9112

MARC East
66 Buttonwood Ct.
Madison, WI 53718
p. 608-241-2929
f. 608-241-1762

MARC Mt. Horeb
225 Blue Mounds St.
Mt. Horeb, WI 53572
p. 608-437-5998
f. 608-437-4998

MARC Stoughton
932 N. Page St.
Stoughton, WI 53589
p. 608-873-5217
f. 608-873-5574

MARC West
805 Forward Drive
Madison, WI 53711
p. 608273-3630
f. 608-273-4638

MARC Sauk County
124 Second St., Ste 39
Baraboo, WI 53913
p. 608-355-6272
f. 608-448-4313

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