MADISON AREA REHABILITATION CENTERS, INC.

Release of Information

I, _____ _____
(Client) *(D.O.B)*

or my legal guardian _____

give permission to Madison Area Rehabilitation Centers, Inc. to realease to the person(s) listed below, information identified below, 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:

_____	Annual Reviews	_____	Psychological
_____	Individual Service Plans	_____	Income
_____	Vocational/Employment Skills	_____	Case Notes
	Medical / Diagnostic	Other:	_____

_____
(Name of Individual/Agency to receive information)

_____
(Address)

_____ _____
(City, State, Zip) *(Phone)*

I understand that I may revoke this consent at any time except to the extend that action has already been taken.

_____ _____
Client Signature Date

_____ _____
Guardian Signature (if applicable) Date