Kinship Connections of Wyoming

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I understand that my Kinship Navigator would like to gather or share information about me or a member of my family with another resource. By signing this form, I am allowing agencies to share or exchange certain information so it will be easier for them to work together effectively to provide or coordinate services or benefits.

I _____ am signing this form for
Full Name of Consenting Person or Persons

_____ authorizing Kinship Connections of Wyoming to:
Self or Name of Minor DOB

_____ release to:

_____ obtain from:

_____ exchange with:

_____

_____

_____

the following information:

☐Assessment Information ☐Financial Information

☐Benefits/Services Needed or Received ☐Medical Records

☐Mental Health Records ☐Educational Records

Other:

_____

_____

for the purpose of:

_____ assessment and/or coordinating supportive services and efforts

_____ other (specific) _____

This consent will automatically expire one (1) year after the date of my signature, or on the following earlier date, condition or event _____.

I understand I have the right to refuse to sign this form and that I may revoke my consent in writing to my Kinship Navigator at any time.

Signature of Consenting Person or Persons Date

Kinship Connections of Wyoming