Release of Information

Camp Courageous • PO Box 418 • 12007 190th Street • Monticello, IA 52310
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CAMP COURAGEOUS®
www.campcourageous.org

Information about the camper and their guardian:

Camper Name:			
Date of Birth:		Medicaid ID:	
Parent/Guardian:			

I authorize the following individual or agency to disclose/receive/exchange information with Camp Courageous:

☐ Personal Physician ☐ Hospital ☐ Pharmacy ☐ Case Manager ☐ Guardian/Home Facility
☐ Other(Specify):

Name or Agency:	
Address:	
City/State/Zip:	
Phone:	Fax:

The following information may be **released** by Camp Courageous:

Yes	No	
☐	☐	Social History / Behavior
☐	☐	Medical Information
☐	☐	Incident / Seizure Reports
☐	☐	Other (Specify): ____________

The following information may be **received** by Camp Courageous:

Yes	No	
☐	☐	Social History / Behavior
☐	☐	Medical History
☐	☐	Incident / Seizure Reports
☐	☐	Other (Specify): ____________

I understand that I am not obligated to authorize the release of any records. I understand that I have the right to inspect the information which is being disclosed to and by Camp Courageous. I understand that I can revoke this consent at any time by contacting Camp Courageous. I understand that any information released prior to the end of this consent, be it by expiration or termination, does not constitute a breach of my (or my camper's) right to confidentiality. I understand that this consent expires one year after the date of signature, unless terminated.

Authorizing Signature:	Date:
Relationship to camper: ☐ Self ☐ Parent/Guardian ☐ Other (specify):	

Specific Authorization for Release of Information Protected by State or Federal Law

*(Sign **ONLY** if any boxes below are marked)*

I specifically authorize the release of data and information relating to:

☐ Substance Abuse (Alcohol/Drugs) ☐ Mental Health (includes psychological testing) ☐ HIV Related Information
☐ Child Welfare ☐ Other (Must specify):

Authorizing Signature:	Date
Relationship to camper: ☐ Self ☐ Parent/Guardian ☐ Other (specify):	

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