DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Public Health
F-40057 (12/03)

AUTHORIZATION AND PERMISSION FOR RELEASE OF INFORMATION TO WISCONSIN BIRTH DEFECTS PREVENTION & SURVEILLANCE SYSTEM AND EARLY CHILDHOOD PROGRAM

Name of Hospital/Clinic _____

Name of Physician _____

Name of Child _____

Child's Date of Birth _____

I give my permission to and understand the following:

1. The hospital, clinic or physician named above must report any suspected or confirmed birth defect to the Wisconsin Birth Defects Prevention & Surveillance System.

2. The hospital, clinic or physician named above will include personally identifiable information about my child as part of the report to the Wisconsin Birth Defects Prevention & Surveillance System. Personally identifiable information includes but is not limited to my child's and my name and address; my child's sex, date of birth, birth weight, and inpatient ID number if appropriate; and the hospital, clinic, or physician's name and address. If I decline to give my permission, a report must still be made but my name and address and my child's name and address will not be disclosed.

3. The purpose of disclosing this information is to comply with mandated state reporting of birth defects and, if appropriate, to allow referral of my child to early childhood services including the Birth to 3 Program and Children with Special Health Care Needs (CSHCN) programs.

I understand that:

1. The Wisconsin Birth Defects Prevention & Surveillance System will not release individually identifying information to any unauthorized person without my permission or that of another parent, guardian, or legal custodian.

2. The Wisconsin Birth Defects Prevention & Surveillance System will only use information reported to assist in assessing the number, type and impact of birth defects in Wisconsin and, potentially, to aid in prevention of future birth defects.

3. Although specialty clinics and physicians are required by law to report birth defects, and hospitals are encouraged to report as well, if I do not give my permission to include my name and address and my child's name and address as part of the report they will not be included, and I may cancel my permission at any time.

4. Granting or not granting my permission will not affect the care given to my child in any way.

My signature is acknowledgement that I have read and understood the information given to me about the Wisconsin Birth Defects Prevention & Surveillance System and that I have received a printed copy of this release.

I am the (Check one): ☐ Parent ☐ Guardian ☐ Legal Custodian

_____ _____
SIGNATURE – Parent, Guardian or Legal Custodian Date Signed

_____
Print Name