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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-01803 (03/2019) | **STATE OF WISCONSIN** |
| **MATERNAL REFERRAL / COMMUNICATION** **WISCONSIN WIC PROGRAM** |
| **Provider Name and Location:**  | **Date:** |
| Participant Name | Date of Birth | WIC Family ID |
|       |       |       |
| Address | City | Zip code |
|       |       |       |
| Language | Phone | Cell phone |
|       |       |       |
| Pre-pregnancy Weight:       | Weight:       Date:       | Height:      Date:       | BMI:      Date:       | Hemoglobin:      Date:       |
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| **Reason for referral/communication and specific health information requested from provider:** |

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| **Participant Authorization** |
| My rights with respect to this Authorization: * By signing this form, I give my permission for WIC and the provider above to share health information and coordinate nutrition services.
* I understand that I have the right to inspect or receive a copy (at a reasonable fee) of the health information I have authorized to be used or disclosed by with this authorization.
* I understand that if I agree to sign this release, I can receive a copy.
* I understand I can cancel this permission at any time by request in writing to my health care provider and WIC. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.
* I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.
* I understand that I am not obligated to sign this authorization as it is will not put WIC eligibility or my WIC benefits at risk.

This authorization is valid for one year, beginning today and ending on      . |
| **SIGNATURE**  | Date Signed |
|  |  |
| Printed Name |
|       |
| **SIGNATURE** – WIC Staff Making Referral | Date Signed |
|  |  |
| **Provider’s Findings and Plan (Please complete & return to WIC to ensure continuity of care):** |
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| **SIGNATURE –** Health Care Provider | Date Signed |
|  |  |
| **WIC Project Information** |
| Name:      Address:      City, State, Zip:       Phone & FAX:       |

This institution is an equal opportunity provider.