

UCP Heartland
13975 Manchester Road
Manchester, MO 63011
Phone: 636-779-2280
Fax: (636) 779-2270

AUTHORIZATION FOR RELEASE OF INFORMATION

Consumer's Name: _____ Date: _____

D.O.B. _____ SSN: _____

I hereby authorize exchange of the following information regarding the above named family member to/from UCP Heartland:

_____ Medical _____ Social _____ Developmental _____ Physical
_____ Emotional/Behavioral _____ Other; Diagnosis/Disability Determination

_____ I authorize UCP Heartland to release the above named
Information to _____
(Insert: St. Louis ARC, Touchpoint, Edgewood, or any other supporting agency)

_____ I authorize _____
(Insert: Regional Center case manager, doctor's name or other licensed clinician who determined the diagnosis)
to release the above named information to UCP Heartland I understand
that UCP Heartland shall keep all information confidential.

This release is effective for one year from the date of signature below.

Parent/Guardian Signature

Date