



**DISCLOSURE AUTHORIZATION**



**FOR CHILD NAMED:** \_\_\_\_\_

This referral is a recommendation for the child and parent/legal guardian to participate in the Straight Talk Education Program held at the University of Michigan Hospital.

**AGENCY CONTACT INFORMATION**

Agency/Department/School/Court name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

**HOSPITAL CONTACT INFORMATION**

<b>University of Michigan Hospital</b> UH 1C435 1500 East Medical Center Dr. Ann Arbor, MI 48109-5033	<b>Karla Klas, RN, BSN, CCRP</b> Managing Director, Injury Prevention and Community Outreach Straight Talk Program Coordinator Phone: <b>(734) 232-3815</b> FAX: <b>(734) 232-3833</b> E-mail: <a href="mailto:ksklas@med.umich.edu">ksklas@med.umich.edu</a>	<b>Kristy Brown, LMT, CMP</b> Program & Event Specialist, Injury Prevention and Community Outreach Phone: <b>(734) 232-3814</b> FAX: <b>(734) 232-3833</b> E-mail: <a href="mailto:kribro@med.umich.edu">kribro@med.umich.edu</a>
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**DISCLOSURE AUTHORIZATION**

I, \_\_\_\_\_ (Parent/Legal Guardian) hereby authorize above named Agency/School/Department/Court, its director or designee, to release information to the above named hospital and Straight Talk Program Coordinators regarding said named child. The intent and nature of this information will concern my child's attendance, progress, services received and recommendations for additional services when deemed necessary. The purpose of this disclosure is to allow the above named agencies and persons to exchange information.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date