Wisconsin Academy for Graduate Service Dogs
1337 Greenway Cross, #157
Madison WI 53713
608-250-9247

Authorization to Release Medical History

Applicant Instructions: Please provide the information requested below. Give this page and the attached Medical History Form to your Physician. Once completed, the forms should be returned to WAGS.

Applicant Name (print): _____

Address: _____

_____

Phone: _____

Physician,
Please release to the Wisconsin Academy for Graduate Service Dogs (WAGS) any requested information regarding my condition. The information you provide will be used to evaluate and assess my application for a WAGS Service Dog. WAGS will keep this information strictly confidential and will not share it with anyone but the professional staff of the agency that is involved in evaluating my application request or in providing services for me.

_____ _____
Applicant Signature Date

* If the applicant is a minor, or under guardianship or conservatorship or a ward of the court, the parent or duly authorized representative is required to sign below pursuant to state and federal law.

_____ _____
Guardian Name (print) Date

_____
Guardian Signature