

## Authorization to Release and Request Information

Authorization is given to share information about:

Child Name: \* \_\_\_\_\_

Date of Birth: \* \_\_\_\_\_.

Between the following parties\*:

<b>Early Intervention Program</b>	
Name: * _____	and
Phone: * _____	
Fax: * _____	
Address: * _____	
_____ <u>UT</u> _____	

Name: * _____
Phone: _____
Fax: _____
Address: * _____
_____
_____

Please send the following information to \_\_\_\_\_ within the next five days. All information received will be kept confidential and will be used for planning purposes only. Thank you.

I authorize the release of the following information from my child's records:

- |  |   |
|--|---|
| <input type="checkbox"/> Most recent well child examination<br><input type="checkbox"/> Most recent developmental evaluation<br><input type="checkbox"/> Medical history<br><input type="checkbox"/> Medical documentation of diagnosis<br><input type="checkbox"/> Immunization record<br><input type="checkbox"/> Vision report<br><input type="checkbox"/> Hearing report<br><input type="checkbox"/> Two-way verbal and/or written communication | <input type="checkbox"/> Hospital Discharge Summary<br><input type="checkbox"/> Early Intervention records including:<br><input type="checkbox"/> Eligibility for early intervention<br><input type="checkbox"/> List of IFSP services<br><input type="checkbox"/> Evaluation/assessment summary<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Other: _____ |
|--|---|

I understand that, as the parent/guardian, I have the right to give or deny permission for the release of my child's information unless the release of information is allowed as one of the exceptions under the rules of Part C of the Individuals with Disabilities Education Act (IDEA) and the Family Education Rights and Privacy Act (FERPA).

I understand that any information released will help determine my child's eligibility for services, developmental progress, and/or types and levels of early intervention services, as well as for planning and coordination of care.

**I understand that this authorization is valid for the entire time my child is receiving early intervention services and will expire no later than my child's third birthday on \_\_\_\_\_. If my child exits \_\_\_\_\_ before the third birthday, this authorization expires on the date of exit.**

I understand that I may withdraw this authorization in writing at any time; however, withdrawal of my authorization will not apply to information already shared under a previously signed authorization.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date (mm/dd/yyyy)