

RELEASE AND CONSENT FOR EXCHANGE OF INFORMATION

Child's Name: _____ DOB: _____

With your written consent, agencies and their representatives may share information with one another. You need to know that:

- ◆ You choose which agencies shall exchange information.
- ◆ You may refuse to sign this exchange form.
- ◆ Information about your child and family is strictly confidential and will only be released to the agencies and/or persons chosen below. Records are maintained by **Project Name** specifying the source of information, the date and purpose of disclosure and with whom information was shared.
- ◆ You have the right to look at and correct the records maintained at **Project Name**.
- ◆ Your rights are preserved under Title 34 Code of Federal Regulations, Family Education Right Privacy Act of 1974.

Please initial by the individual agencies of the **Project Name/Initiative/Collaborative** to permit the release and/or exchange of information. Records may include medical, health, developmental, speech/language, educational, hearing, vision and/or psychological information.

NAME OF PROGRAMS/AGENCIES

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Identify Names And Addresses below:

Primary Care Physician/Clinic _____

Other Physicians or Specialists _____

Hospital of Birth _____

Other Hospitals _____

Other Agencies or Specialists _____

This authorization is in effect for one year from date of signature unless revoked in writing prior to that date. A photocopy of this form shall be as valid as the original. Copy of this authorization is to be given to parent/guardian.

Signature of Parent/Guardian/Surrogate _____ Date _____ Signature of Parent/Guardian/Surrogate _____ Date _____

Parent/Guardian Address _____ City/State/Zip _____ Phone _____