

[NAME OF AGENCY, ADDRESS & PHONE #]
CONSENT FOR USE, DISCLOSURE AND/OR RELEASE
OF PERSONAL AND HEALTH INFORMATION
 Developmental Screening Program

YOUR INFORMATION:

LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO CHILD
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CHILD'S INFORMATION:

LAST NAME	FIRST NAME/MIDDLE INITIAL	DATE OF BIRTH	CHILD IDENTIFYING #
ADDRESS	CITY, STATE	ZIP CODE	PHONE NUMBER

I. PERSON OR AGENCY PROVIDING THE INFORMATION:

The persons or agency may release my child's personal, health, and/or education information: (The information to be released is described in Section II below.)

Agency/Name:

Address:

City, State, Zip Code:

Telephone No.:

II. INFORMATION THAT MAY BE RELEASED:

The persons or agencies marked in Section III below may view, copy, release and exchange the information or records marked below (*please check all that apply to your child's needs now and in the future*). This information may be shared verbally, in writing, and/or by email or fax:

- | | |
|--|--|
| <input type="checkbox"/> Medical Information, including but not limited to operative, emergency, radiology, consultations, progress notes. | <input type="checkbox"/> Occupational/Physical Therapy Information |
| <input type="checkbox"/> Medication Information | <input type="checkbox"/> Educational Records |
| <input type="checkbox"/> Speech/Language Information | <input type="checkbox"/> Other Developmental Information |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

SPECIFIC AUTHORIZATIONS:

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- I specifically authorize the release of information pertaining to mental health diagnosis or treatment or psychological information (Welfare & Institutions Code, §§5328, et seq)

MY CHILD'S INFORMATION MAY BE USED TO:

1. Get more services for my child after the screening.
2. Fill the requirements so that my child may go to school.

3. Evaluate screening programs by the [NAME OF PROGRAM AND AGENCY.] and the Children and Families Commission of Orange County. I know that my child's name will not be released in any evaluation reports that may be made public.

III. INFORMATION MAY BE RELEASED TO THE FOLLOWING PERSONS OR AGENCY(IES):

(Referring Agency: If you check a box marked "other," please write the position of agency contact and name of the agency.)

I know that the service team includes the persons and/or agencies marked below *(Please check all that apply to your child's needs now and in the future.)*:

- | | |
|--|--|
| <input type="checkbox"/> Orange County Health Care Agency (including California Children Services and Behavioral Health) | <input type="checkbox"/> School District (specify: _____) |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Teacher |
| <input type="checkbox"/> Physician | <input type="checkbox"/> School Psychologist |
| <input type="checkbox"/> Therapist | <input type="checkbox"/> School Counselor |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> School Administrator |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Speech/Language Therapist |
| | <input type="checkbox"/> Case Manager / Community Facilitator |
| | <input type="checkbox"/> School Nurse |
| <input type="checkbox"/> Orange County Social Services Agency | <input type="checkbox"/> Pediatric Health Services (CUIDAR, For OC Kids NDC, EDAC, Asthma/Chronic Lung, Metabolic) |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Nurse Practitioner |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Physician |
| | <input type="checkbox"/> Social Worker |
| | <input type="checkbox"/> Psychologist |
| | <input type="checkbox"/> Family Support Worker |
| <input type="checkbox"/> Regional Center of Orange County | <input type="checkbox"/> CalOptima |
| <input type="checkbox"/> Service Coordinator | <input type="checkbox"/> Insurance Enrollment Staff |
| <input type="checkbox"/> Primary Health Care Provider | <input type="checkbox"/> Help Me Grow |
| | <input type="checkbox"/> Care Coordinators/Liaisons |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

VOLUNTARY: I know that I do not have to sign this consent form. I can refuse to sign this consent form, and it will not affect the services my child gets from the [ORGINATING AGENCY].

LENGTH OF TIME: This consent will be valid from the date that I sign this form until _____(date). If no date is entered, the form will be valid for one year after the date that I sign the form.

WITHDRAWAL: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to the person or agency in Section I. The withdrawal will be valid as soon as the person or agency gets my note, but will not apply to information that has already been shared after I signed the consent form.

SHARING OF INFORMATION: I know that my child’s information may be shared more than once by the persons and/or agency(ies) in Sections I and III. The information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other State and Federal laws.

COPY: A copy of this consent form will be as good as the original. I know that I have a right to get a copy of this consent form if I ask for one.

Signature:	Date:
Relationship to patient:	

This authorization is compliant with the requirements of HIPAA and Cal. Civil Code § 56.11.