Crossroads Head Start / Early Head Start D-216
Authorization To Release & Receive Information

FROM/TO: *Crossroads HS/EHS* **TO/FROM:** _____

_____ _____
Contact Person/Contact Information Contact Person/Contact Information

Child's Name: _____ **Date of Birth:** _____ /_____/ _____

Parent/Guardian: _____ **Phone #:** _____

_____
Address, City, State, Zip

I (we), the undersigned, do hereby authorize the above persons, education institutions, firms, physicians, clinics, hospitals or agencies to release and/or receive the following confidential information in written or verbal form: (check all that apply)

✓ Any information necessary for provision of services ___ Treatment Plan ___Diagnosis ___Dental

✓ Requested documentation from providers ___ Treatment Provided ___Medications ___Physical

___ Education Plan (IEP/ HSS/IFSP) ___ Evaluation/testing results ___Progress Notes ___Well Child

___Immunization ___Pertinent Medical Information_____

The above information is released for the following purpose and that purpose only. Any other use is forbidden: *Referral for services/coordination & collaboration of services*

I understand that my records are protected by state and federal law, and cannot be disclosed without my written consent unless otherwise provided for by law. I also understand that I may revoke this consent in writing at any time unless action has already been taken based upon this consent and in any event this consent expires one year from the date of signature.

I want the agency listed above to accept a copy of this form as valid consent to share information on an as needed, if needed basis to assist with service coordination and treatment planning. If I do not sign this form, information will not be shared and I will have to contact the agency personally to give them information they need. I hereby release any person, educational institution, firm, physician, clinic, hospital, or agency from liability for information furnished pursuant to this authorization.

_____ _____/_____/_____
Signature of Authorizing Person Date

_____ _____/_____/_____
Staff signature, credentials & title Date

The Head Start/Early Head Start program is unable to pay for this service and we make no charge when we respond to authorized requests for information.

If the records to be disclosed are education recourse, they are maintained and released in accordance with the Family Education Rights and Privacy Act (FERPA). Parents or eligible students shall be provided a copy of the records to be disclosed if requested.

THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION THAT COULD BE CONSIDERED INFORMATION ABOUT COMMUNICABLE DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations when applicable (42 CFR Part 2) prohibit you from making any further disclosure of this information except with specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $5,000.00 in the case of each subsequent offense.