RELEASE OF INFORMATION AUTHORIZATION

**Authorization to Obtain Information:**

Permission is hereby granted to the Service Coordinator, representing

(Birth to Three Program Area Name)

To obtain the following specific information regarding

(Child’s Name) (Date of Birth)

Specific information to be obtained:

This information is to be obtained from (please specify PERSON, PHYSICIAN SERVICE PROVIDER OR INSTITUTE)

I acknowledge that I am legally authorized as my child’s parent/guardian to authorize the release of the above-requested information.

I understand that the information in my child’s health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I further understand any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, covered health care provider, the Medical Information Bureau, Incorporated, or other clearinghouse listed above may give, disclose, and release the information requested within this release without restriction.

I further understand there is a potential for information disclosed pursuant to this release to be subject to re-disclosure by the recipient and no longer protected by HIPAA.

I understand the purpose of this release is to facilitate the coordination of care and provision of services for my child and family.

This consent is subject to revocation at any time except to the extent that the program, which is to make the disclosure, has already acted in reliance on it. If not previously revoked, this consent will terminate upon \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or one year from signature.

**(List specific date, event or condition)**

**Signed**

(Signature of parent or guardian)

# Address

**Date Authorized**

**I understand that this information will be used to assist in the coordination of care and provision of services for my child and family.**

# Authorization to Release Information:

Permission is hereby granted to the Service Coordinator representing

(Birth to Three Program Area Name)

to release orally or in writing (including reproduction) of any official records relating to my child

 .

(Child’s Name) (Date of Birth)

Specific information to be released:

Information will be released to: (please specify PERSONS, PROGRAM, SERVICE PROVIDERS or INSTITUTION)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Signed:

This consent is subject to revocation at any time except to the extent that the program, which is to make the disclosure, has already acted in reliance on it. If not previously revoked, this consent will terminate upon: .

**(List specific date, event or condition)**

(Signature of parent or guardian)

# Address:

**Date Authorized:**

**I understand that this information will be used to assist in the coordination of care and provision of services for my child and family.**