Early On® Request for Protected Information (Health)

Child Information	
Child's Name:	Date of Birth:
Parent's/Guardian's Name:	

Purpose

The purpose of this request is to collect information necessary to determine your child's eligibility for *Early On*, and to plan and provide services as determined through the multidisciplinary team process.

Medical Provider(s) Authorized to Share Information with *Early On*

The medical provider(s) listed below have permission to share the specific information listed about my child.

Medical Provider:	Specific information to be shared with *Early On:*
Medical Provider:	Specific information to be shared with *Early On:*

Authorization

My signature below means I understand that:

- ✓ My authorization to allow the sharing of information about my child is voluntary and expires upon exit from *Early On* or my child's third birthday.
- ✓ Information regarding behavioral and mental health services or communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Deficiency Syndrome or AIDS related complex) may be shared if I initial here ____ or if I list this type of information above.
- ✓ Information received under this authorization becomes part of my child's educational record, is protected by the Family Educational Rights and Privacy Act (FERPA), and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).
- ✓ Information may be re-disclosed by *Early On* as part of the educational record protected by FERPA.
- ✓ I may refuse to sign this authorization.
  - o Refusal to sign may affect the ability of *Early On* to obtain information necessary to demonstrate that my child meets *Early On* eligibility criteria.
  - o If my child is found eligible for *Early On*, refusal to sign this authorization will not affect my ability to obtain *Early On* services. However, the information obtained can help provide services that are individualized for my child.
- ✓ I may revoke or cancel consent at any time, without penalty, by notifying *Early On* in writing. Information that has already been shared based on this authorization cannot be taken back.

I have read and understand this authorization form (or it has been read to me in a language I understand) and:

☐ I authorize the above listed medical provider or designee to engage in verbal, written, and/or electronic communication in order to share specified records and information.
OR
☐ I do not wish to have any information shared at this time.

Signature of Parent/Guardian:	Relationship to Child:	Date: