

## Authorization to Release or Obtain Information

We are committed to the privacy of your information. Please read this form carefully.

### Participant's Information:

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Preferred Contact Method: Phone E-Mail

### **Information to be shared:**

Ages & Stages Questionnaires®, Third Edition (ASQ®-3)

Ages & Stages Questionnaires®: Social-Emotional, Second Edition (ASQ®:SE-2)

Status of Referral Other (describe): \_\_\_\_\_

**Please Check:**  **Release/Send information to:**  **Obtain/Get information from:**

Name of Individual: \_\_\_\_\_ Organization: \_\_\_\_\_

Address: \_\_\_\_\_  

Street
Town/City
State
Zip Code

Telephone: \_\_\_\_\_ Email address (optional): \_\_\_\_\_

**The purpose of this disclosure is to coordinate and communicate about my child's care and development.**

**To share the information with others by EMAIL or other electronic means, please initial below.**

I understand that email and the internet have risks that the office sharing information cannot control. It is possible that the emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask to send the information by email or program database. **Initial Here:** \_\_\_\_\_

I understand and agree that:

- I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.
- "Information" relating to my child may be in written, spoken and/or electronic format, and may include records from healthcare providers (such as doctors, hospitals, counselors) or other professionals (such as educators).
- My signature allows the people/offices named above to discuss my child's information for the purposes noted.
- My child's information will be kept confidential as required by law. If I choose to share this information with others who are not legally required to keep it private, it may no longer be protected by confidentiality laws.
- I may revoke (take back) my permission to release this information by filling out the [Revocation Form](#) and sending it to the office that shared the information. The Revocation Form is effective only after it is received and does not apply to information that was already shared.
- I may refuse to disclose all of the information, however, if I take back my permission or refuse to release some or all of the information, my choice could lead to an improper diagnosis or treatment, or denial of insurance.
- This form expires one year from the date below unless I write an earlier date here: \_\_\_\_\_
- This form permits additional releases of information until it expires or is revoked.

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

