|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Name |  | Date |  |
| Child’s Date of Birth |  | FRC |  |

As a parent, you have the right to give permission or not give permission for the release of your child’s records to other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules of Part C of the Individuals with Disabilities Education Act (IDEA) and the Family Education Rights and Privacy Act (FERPA).

**I Hereby authorize the exchange of Information orally, in writing or electronically between Children FIRST Therapy and the agencies/persons listed below**

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency/Person:** |  | | |
| Address: |  | City, State, Zip |  |
| Phone: |  | Fax |  |
| **Agency/Person:** |  | | |
| Address: |  | City, State, Zip |  |
| Phone: |  | Fax |  |
| **Agency/Person:** |  | | |
| Address: |  | City, State, Zip |  |
| Phone: |  | Fax |  |
| **Agency/Person:** |  | | |
| Address: |  | City, State, Zip |  |
| Phone: |  | **Fax** |  |

RECORDS TO BE SENT TO: Children FIRST Therapy- N. Pines Rd Ste 1, Spokane Valley, WA 99206

Attn: Allyson Blackhart, RN

Phone: 509-315-5711 Fax: 509-443-4170

**I authorize the exchange of Information for the following purposes (Check all that apply)**

Determining eligibility for early intervention services

Identifying appropriate early intervention services through the IFSP process.

Sharing evaluation/assessment results and all progress notes

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The records to be exchanged include (Check all that apply).**

Medical/Health information Current developmental information

Evaluation/assessment/results IFSPs/Progress notes

Mental health information Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This authorization in valid:**

From date: \_\_\_\_\_\_\_\_\_\_\_ to date: \_\_\_\_\_\_\_\_\_\_\_

I understand that the information obtained will be treated in a confidential manner by Children FIRST Therapy under the provisions of Part C of IDEA and FERPA. IDEA and FERPA prohibit disclosure of personally identifiable information without consent except in limited circumstances. I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under any prior consent for release.

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Patient Representative Name (printed) Relationship to Patient

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

Signature of Patient Representative Date