



Authorization for Release of Information

I, _____ hereby authorize the following agencies to engage in verbal, written or electronic communication to coordinate services for...

Name Of Child: _____

Child's Date of Birth: _____

Agency:

(Check All That Apply)

- 4C/Early Head Start
- Child Find (FDLRS)
- Children's Medical Services
- County School: _____
- County Health Dept: _____
- Department of Children and Families
- Division of Blind Services
- Easter Seals
- Early Steps/Part C
- Pediatrician: _____
- SSI
- United Cerebral Palsy of _____
- Other: _____

Types of Information That May Be Shared:

(Check All That Apply)

- Psychological Testing
- Social/Developmental History
- Speech/Language and Hearing Reports
- Vision/Hearing/Screening Results
- Occupational/Physical Therapy Records
- Developmental Assessment Reports
 - IFSP or IEP
- Medical Information and Reports Including:
 - Medical Records
 - Immunizations
 - Physical Examinations Reports
 - Laboratory Reports
 - HIV test results
 - Other List:
- Other: _____

I am aware that the information shared will be strictly confidential and cannot be released to anyone else without my written consent. I am aware that I may deny consent to any of the agencies listed above and that I may withdraw my consent at any time, by notifying UCP of Central Florida in writing.

Signature of Parent or Legal Guardian

Date

Witness

Date

The execution of this form does not authorize the release of information other than that specifically described above. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify.