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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION** | | | | | | | | | | | | | | | | | |
| **Child:** |  | | | | |  | | | | |  | |  | | | |  |
|  | **Last Name** | | | | | **First Name** | | | | | **Middle Name** | | **ID#** | | | | **DOB** |
| **Parent/**  **Legal Guardian** |  | | | | | |  | | | | |  | | |  | | |
|  | **Last Name** | | | | | | **First Name** | | | | | **Middle Name** | | | **Phone#** | | |
| I have provided my signature below for the agencies/providers for which I have given permission to disclose and/or obtain information for the purposes of improving the wellbeing of my child named above via mail, phone, fax, video, or secure encrypted email. I understand the following:   * That information may be disclosed to parties listed below as required for billing and access to services and continuity of care. * Only the minimum amount of information necessary to fulfill a request will be released/obtained. * There may be a charge per page, plus postage and handling, for copy services unless copies are provided directly to an entity for the purposes of continuity of care. | | | | | | | | | | | | | | | | | |
| * Children’s Medical Services Program(s) | | | | | | | | * Local Education Agency/School System | | | | | | | | | |
| * Head Start/Early Head Start | | | | | | | | * Florida Diagnostic and Learning Resources System (FDLRS/Child Find) | | | | | | | | | |
| * Office of Disability Determinations (SSI) | | | | | | | | * Department of Health, Birth Defects Registry | | | | | | | | | |
| * Department of Children and Families, Voluntary Family Services | | | | | | | | * Department of Health, Newborn Screening Program | | | | | | | | | |
| * Department of Education | | | | | | | | * Early Learning Coalition (ELC) | | | | | | | | | |
| **Agency** | | | | **Name** | | | | | | | | | | **Phone#** | | | |
| Medicaid/ Managed Care Plan | | | |  | | | | | | | | | |  | | | |
| Private/Commercial Insurance | | | |  | | | | | | | | | |  | | | |
| Pediatrician/Physician | | | |  | | | | | | | | | |  | | | |
| Hospital | | | |  | | | | | | | | | |  | | | |
| Other | | | |  | | | | | | | | | |  | | | |
| **INFORMATION TO BE DISCLOSED/OBTAINED: (check selection)** | | | | | | | | | | | | | | | | | |
| General Medical Record(s) | | | | | Progress Notes | | | | | History and Physical Results, including diagnostic information | | | | | | | |
| Immunizations | | | | | Consultations | | | | | Individualized Family Support Plan/Evaluation/Assessment Reports | | | | | | | |
| Other (please specify): | | |  | | | | | | | | | | | | | | |
| **I specifically authorize release of information relating to: (check selection if applicable)** | | | | | | | | | | | | | | | | | |
| HIV test results for non-treatment purposes  Substance Abuse Service Provider Client Records  Mental Health notes  **EXPIRATION DATE:** This authorization will expire (insert date or event)      . I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.  **RE-DISCLOSURE:** I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.  **CONDITIONING:** I understand that completing this authorization form is voluntary. I realize that services will not be denied if I refuse to sign this form.  **REVOCATION:** I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to my service coordinator. I understand that the revocation will not apply to information that has already been released in response to this authorization. | | | | | | | | | | | | | | | | | |
| **Parent/ Legal Guardian** | |  | | | | | | |  | | | | | | |  | |
|  | | **Print Name** | | | | | | | **Signature** | | | | | | | **Date** | |

