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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.
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| * Children’s Medical Services Program(s)
 | * Local Education Agency/School System
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| * Head Start/Early Head Start
 | * Florida Diagnostic and Learning Resources System (FDLRS/Child Find)
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| * Office of Disability Determinations (SSI)
 | * Department of Health, Birth Defects Registry
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| * Department of Children and Families, Voluntary Family Services
 | * Department of Health, Newborn Screening Program
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| * Department of Education
 | * Early Learning Coalition (ELC)
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| **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** |

