CONSENT FOR EXCHANGE OF INFORMATION
between Child Care Health Consultant and/or Child Care Program and
Other Individuals/Programs/Agencies
(No referral involved)

I understand that information regarding my child is generally confidential and may not be given to employees of other schools, public agencies or individual professionals in private practice without my consent or other legal requirement.

I, ____________________________________________, hereby consent to the release of the following information initialed and checked below, regarding my child ____________________________________ held by __________________________________________________ to _________________________________________.

___ ❏ Educational/Developmental Records
___ ❏ Diagnostic Assessments/Evaluations (Occupational/Physical Therapy, Speech and Language Pathology, Psychological, Social-emotional)
___ ❏ Developmental/Health Screening(s); please specify: ___________________________________________
___ ❏ Medical      ___ ❏ Dental       ___ ❏ Immunizations Records
___ ❏ Other; please specify: ________________________________________________________________

I authorize communication and exchange of information between ____________________________________ and ___________________________________ to discuss the above indicated records/conditions, and/or findings. I also authorize communication and exchange of information between _____________________________________ and __________________________________. Further, __________________________________ is authorized to share the information gained with his/her supervisor(s) and/or child care health consulting staff working directly with her/him. Consent for release of information and authorization of communication shall be for the limited purpose of understanding and addressing my child’s needs.

This consent is voluntary and I understand that I can withdraw my consent for my child at any time. Unless I withdraw this consent, this authorization will be effective for the period my child is continuously enrolled in the _________________________________________________. By signing below, I am confirming that I have read, understood and agree to the above.

Parent/Guardian Name: __________________________________________________
Parent/Guardian Signature: _____________________________________________ Date: __________________

NOTE: In accordance with the Health Insurance Portability and Accountability Act (HIPPA) and applicable California laws, all personal and health information is private and must be protected.