Consent for Release of Information and Referral

from Child Care Health Consultant and/or Child Care Program to Other Individuals/Programs/Agencies

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.

Consent for Release of Information

I, ______________________________ (FULL NAME OF PARENT/GUARDIAN), hereby consent to the release of the following information

initialed and checked below, regarding my child ______________________________ (FULL NAME OF CHILD) held by

______________________________ (FULL NAME OF INDIVIDUAL OR AGENCY/ADDRESS) to ______________________________ (FULL NAME OF CHILD CARE HEALTH CONSULTANT).

____ (INITIAL) ☐ Educational/Developmental Records

____ (INITIAL) ☐ Diagnostic Assessments/Evaluations (OCCUPATIONAL/PHYSICAL THERAPY, SPEECH AND LANGUAGE PATHOLOGY, PSYCHOLOGICAL, SOCIAL-EMOTIONAL)

____ (INITIAL) ☐ Developmental/Health Screening(s): ______________________________ (PLEASE SPECIFY)

____ (INITIAL) ☐ Medical ____ (INITIAL) ☐ Dental ____ (INITIAL) ☐ Immunization Records

____ (INITIAL) ☐ Other: ______________________________ (PLEASE SPECIFY:)

Consent for Referral

I also authorize communication and exchange of information between: ______________________________ (NAME OF INDIVIDUAL/AGENCY HOLDING RECORDS)

and/or: ______________________________ (NAME OF CHILD CARE HEALTH CONSULTANT) and ______________________________ (NAME OF CHILD CARE PROGRAM).

Further, ______________________________ (NAME OF CHILD CARE HEALTH CONSULTANT) 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 ______________________________ (NAME OF CHILD CARE PROGRAM).

By signing below, I am confirming that I have read, understood and agree to the above.

Name: ______________________________ (PRINT FULL PARENT/GUARDIAN NAME) **Signature:** ______________________________ (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.