



# 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, \_\_\_\_\_, hereby consent to the release of the following information  
FULL NAME OF PARENT/GUARDIAN  
initialed and checked below, regarding my child \_\_\_\_\_ held by  
FULL NAME OF CHILD  
\_\_\_\_\_ to \_\_\_\_\_.  
FULL NAME OF INDIVIDUAL OR AGENCY/ADDRESS FULL NAME OF CHILD CARE HEALTH CONSULTANT

- Educational/Developmental Records  
INITIAL
- Diagnostic Assessments/Evaluations (OCCUPATIONAL/PHYSICAL THERAPY, SPEECH AND LANGUAGE PATHOLOGY, PSYCHOLOGICAL, SOCIAL-EMOTIONAL)  
INITIAL
- Developmental/Health Screening(s): \_\_\_\_\_  
INITIAL PLEASE SPECIFY
- Medical  Dental  Immunization Records  
INITIAL INITIAL INITIAL
- Other: \_\_\_\_\_  
INITIAL PLEASE SPECIFY:

## Consent for Referral

I also authorize communication and exchange of information between: \_\_\_\_\_  
NAME OF INDIVIDUAL/AGENCY HOLDING RECORDS  
and/or: \_\_\_\_\_ and \_\_\_\_\_.  
NAME OF CHILD CARE HEALTH CONSULTANT NAME OF CHILD CARE PROGRAM  
Further, \_\_\_\_\_ is authorized to share the information gained with  
NAME OF CHILD CARE HEALTH CONSULTANT

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:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
PRINT FULL PARENT/GUARDIAN NAME PARENT/GUARDIAN SIGNATURE:

NOTE: IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND APPLICABLE CALIFORNIA LAWS, ALL PERSONAL AND HEALTH INFORMATION IS PRIVATE AND MUST BE PROTECTED.

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<http://cchp.ucsf.edu>