Shiawassee County 989-725-2581 or
Toll Free 1-866-725-7792 Fax 989-725-1312

Authorization to Release *Early On*® Record

Child Information

Child's Legal Name: DOB:

Parent's/Guardian's Name:

Purpose

The purpose of this form is to obtain parental consent to release information from the Early On record to other agency(ies) or person(s).

Agency(ies)/Person(s) to Whom Information May Be Released

Info to Share (Code)	Initial	Agency/Person		Info to Share (Code)	Initial	Agency/Person
		Shiawassee County Health Department				Shiawassee Head Start
		Shiawassee Community Mental Health Authority				Hospital (specify)
		Shiawassee County Department of Human Services				Physician (specify)
		Shiawassee Regional Education Service District				Other (specify)
		Local School District (specify)				Great Start Database

Information Codes

1. Educational Records (including IFSP's from LEA's and ISD/RESD's).
2. Progress Reports
3. Discharge Summaries
4. Psychological Reports
5. Social/Developmental History
6. Staffing Reports/Provider Notes
7. Speech/Language/Communication Reports
8. Developmental Evaluations and Assessments
9. Gross/Fine Motor Reports, includes subsets
   9 (A) Occupational Therapy Reports
   9 (B) Physical Therapy Reports
10. IFSP Service Plan (parent-signed Initial and subsequent signed IFSP's).
11. Medicaid Number (This will also be used to access information associated with the number that is needed to ensure diagnosis, treatment, and payment of services).
12. Other (Specify)
13. Full *Early On* Record

Authorization

My signature below means I understand that:

√ My authorization to allow the sharing of information about my child is voluntary and expires upon exit from *Early On* or my child's third birthday.

√ *Early On* has no control over the agency(ies)/person(s) I have listed to receive my protected information. Therefore, my protected information disclosed under this authorization may no longer be protected by the requirements of the Family Educational Rights and Privacy Act (FERPA), and will no longer be the responsibility of *Early On.*

√ Refusal to sign this authorization will not affect my ability to obtain *Early On* services.

√ I may revoke or cancel consent at any time, without penalty, by notifying *Early On* in writing. Information that has already been shared based on this authorization cannot be taken back.

I have read and understand this authorization form (or it has been read to me in a language I understand) and:

□ I authorize *Early On* to engage in verbal, written, and/or electronic communication with the identified agency(ies) or person(s) in order to release the information listed.

OR

□ I do not wish to have any information released at this time.

Signature of Parent/Guardian:	**Relationship to Child:**	**Date:**