Consent to Share/Release Information with CDSA and Schools

Name	Date of Birth	Chart Number	Patient

School, School System, or CDSA	Teacher/ Preschool Coordinator/CDSA Contact	Age or Grade

This release has been explained to me. I understand what information is to be released and why. I also understand that there are laws that protect my privacy. I understand that I may cancel this release at any time except when action has been taken based on this consent. I, hereby, give my permission to the **Agency/Facility** named to exchange information as described below. I also give permission for medical records listed below to be released to the requesting **Agency/Facility**. This consent is valid for one year from the date signed.

Signature _____ Date _____Phone _____
(Circle one – Patient, Parent or Legal Guardian)

Street Address _____ City _____ State _____

Witness _____ Title _____ Date _____

Information to be exchanged (Please circle below)

Physical/Medical Information, Home Health Records, Hospital Records; Mental Health (Psychological/Psychiatric),

Emotional, Behavioral, Developmental, and/or Educational screenings/evaluation(s), Audiological and Vision screening results

Medical Home Feedback Form: Established Conditions, Conditions that Adversely Impact Educational Performance CDSA/Preschool Program eligibility determination results, services provided on the IEP/IFSP, Recommended additional community services.

Other:_____

Agencies Exchanging Information:

Name of County Schools_/ CDSA/ Community Agency:	**Name of Medical Practice:**
_____	_____
Mailing Address	Mailing Address
_____	_____
City State Zip	City State Zip
_____	**Medical Records Dept.** _____
Attention Phone Fax	Attention: Phone Fax

Two way release for Medical Home and CDSA/School
January 2015