



Date: _____

Authorization for Mutual Exchange of Information

Child's Name: _____ **Date of Birth:** _____

I hereby authorize the mutual exchange of records pertaining to my child, between Children's Learning Center and the following agencies: *Please include all early intervention programs, schools, physicians, optometrists, ophthalmologists, and any other specialists/therapists. (occupational, physical, speech, audiology, etc.)*

Name: _____

Address: _____ **Phone:** _____

Ophthalmologist: _____

Address: _____ **Phone:** _____

Optometrist: _____

Address: _____ **Phone:** _____

Audiologist: _____

Address: _____ **Phone:** _____

Therapist (please specify type): _____

Address: _____ **Phone:** _____

State Agency: _____

Address: _____ **Phone:** _____

Child Find: _____

Address: _____ **Phone:** _____

Other: _____

Address: _____ **Phone:** _____

The receiving party will not disclose shared information to any other part without signed consent.

The specific records to be disclosed pertain to:

- To coordinate care with my child's physician/ophthalmologist/audiologist
- To consult with my family's service coordinator; and early intervention service providers about the developmental impact of my child's medical condition; and to interpret medical and health records for eligibility determination and program planning.
- To coordinate with my child's school(s).
- Other _____

I understand that this authorization may be revoked at any time by making a written request to Children's Learning Center (CLC). I understand that signing this authorization is not a condition of receiving future services at CLC; and there is potential for redisclosure of this information to others, in which case it may no longer be protected under the HIPAA Privacy Rule. It is CLC's policy, not to disclose any student information without the consent of parent or guardian consent. I certify that I am the parent or legal guardian of the child named above or that I am a student of majority age and have the authority to sign this release.

Parent/Guardian Name (print) _____ **Signature of Parent/Guardian** _____

Relationship to Child: _____

Address _____ **City** _____ **State** _____ **Zip Code** _____