Snohomish County Early Childhood Education and Assistance Program

Authorization to Release Confidential Information

Child's Name (First, Middle, Last)	Date of Birth

Please list any identifier(s) to assist in locating records i.e. Medical Identification/Record No. (Medical Coupon)

By signing below, I understand that:

- This authorization may be revoked in writing at any time except to the extent action has been taken prior to revocation.
- This authorization will expire in 90 days after my signature date below or sooner in which case this authorization will expire on this date or event _____. (Please initial _____)
- I may inspect or receive a copy of the information being released at my request.
- Any records received will be treated as confidential by ECEAP.
- The information used or disclosed may be released by the recipient and no longer protected by the Federal Privacy Rule.
- This authorization is voluntary and I may refuse to sign this authorization to release information which will not affect my child's ability to participate in ECEAP.

INFORMATION TO BE RELEASED **FROM**:

I hereby authorize the following person(s)/organizations to release the type of information requested below.

Person(s) _____
And/or Organization _____
Street Address _____
City, State, Zip _____
Phone No. _____

INFORMATION TO BE RELEASED **TO**:

I authorize the following person(s)/organizations to receive the information requested in this release by verbal and other means identified by initialing below. (Use N/A, if not used)

_____By mail _____By Fax No. _____
Person(s) _____
And/or Organization _____
Street Address _____
City, State, Zip _____
Phone No. _____

If this release of information is to another ECEAP site and requires a fee, please contact the specific ECEAP site to arrange payment.

REASON FOR RELEASE OF INFORMATION:

Agree (Please initial to Agree or place N/A)

_____ At the request of the Parent/Legal Guardian for the health, safety and educational purposes of their child while enrolled in ECEAP.

_____ At the request of ECEAP staff for observation of a child and/or consultation with a specialist to plan for a child while enrolled in ECEAP

_____ Other (please specify) _____

_____

_____

TYPE OF INFORMATION

(Please select **all** that apply by initialing to Agree or a N/A when Not Applicable)

Agree		Dates of Service
_____	Well Child/Physical Exam	_____
_____	Immunization Records	_____
_____	Dental Exam/Treatment	_____
_____	Child Health Plan	_____
_____	Education information	_____
_____	Special Education services information	_____
_____	Mental Health services information	_____
_____	Other _____	_____
_____	Other _____	_____

SPECIFIC RELEASE OF PROTECTED HEALTH INFORMATION (Initials required)

I understand that **if** these records contained any information relating to sexually transmitted diseases, (including HIV/AIDS), alcohol or drug abuse treatment, behavior or mental health services, (Please select **all** that apply by initialing to Agree or a N/A when Not Applicable)

_____ I give my permission to release the records if it contains any of the protected information mentioned above.

_____ I do not give my permission to release the protected information mentioned above.

_____ I give my permission to release the records if it contains protected information relating only to:

Please specify: _____

REDISCLOSURE PROHIBITED of Protected Health Information: This information has been disclosed to the recipient above from confidential records which are protected by Federal and State laws. This prohibits the recipient from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient for further disclosure.

I understand that all items on this form have been completed and my questions about this form have been answered.

Signature of the Parent/Legal Guardian _____ Date _____ Phone _____

Relationship to the child _____ Signature of Witness or Interpreter if available _____