Lower Shore Early Intervention Program
CONSENT TO RELEASE AND RECEIVE INFORMATION

Parent(s)/Guardian Name:_________________________________ **County:** ____________________
Parent(s)/Guardian Street Address: ________________________ **Telephone #:** _______________
____ **Fax #:** ____________________
Parent(s)/Guardian E-Mail: ______________________________ **Cell #:**_____________________
Child's Name: ____ **DOB:** ____________ **Sex:**_____

1. The program has my permission to exchange information with the following professionals or agencies:

☐ send to   Agency/Individual: ____
☐ receive from   Address: ____
☐ verbally discuss   ____
E-Mail: ____
Telephone #: _________________ Fax #: _________________

☐ send to   Agency/Individual: ____
☐ receive from   Address: ____
☐ verbally discuss   ____
E-Mail: ____
Telephone #: _________________ Fax #: _________________

2. Information to be exchanged:

☐ Name and Contact Information   ☐ Clinician's Report
☐ Assessment Information   ☐ Reason for Referral
☐ Progress Notes   ☐ Medical Records
☐ Other: __________________   ☐ Other: __________________

3. Reason this information is being shared:
To assess and evaluate child and provide appropriate behavior intervention services.

4. This authorization is valid for 12 months.

5. I may revoke this authorization at any time.

______________________________________ ____________________ _________________
Parent's/ Guardian's Signature   Relationship to Child   Date

______________________________________ ____________________
Interventionist Signature   Date