CCA the Children's Center for Autism

Release of Information

NAME OF CHILD _____ DATE OF BIRTH_____

NAME OF PARENT/LEGAL GUARDIAN_____

ADDRESS_____

I authorize the Children's Center for Autism to ____ obtain ____ release ___share information with the person/agency below through written form, oral discussion, or electronic format. I understand that I have the right to revoke this authorization at any time.

_____

_____

_____

(Person or Agency) (Telephone / Fax)

Please initial the appropriate boxes below to indicate approval.

□ Family Demographics (names, address, phone, etc.), dynamics, and history

□ Developmental Evaluations/Assessments

□ Behavior Treatment Plan

□ Psychological Reports

□ Medical Information/History

□ Immunization Record

□ Hearing Screenings/Evaluations

□ Family Support Plan

□ Discharge Summary

□ OT Records

□ SLT Records

□ PT Records

□ Vision Screenings/Evaluations

□ First name and/or picture to appear on CDC/CCA Bulletin Boards and within the Center

□ Other:_____

Reason For Request:_____

_____

All information hereby requested by the CCA will be strictly confidential and will not be released without written consent. This release is effective until _____.

_____ _____

(Signature of Parent/Legal Guardian) (Date)

_____ _____

(Witness) (Date)

This release is in compliance with the privacy regulations set forth by the Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA).

CDC Staff Only Verified by: _____ Date: _____

Phone: 931-684-2293 Fax: 931-680-0029 Email: cca@cdctn.org