Consent to Request or Release Information
Educational and Developmental Intervention Services (EDIS) - Early Intervention Services

Location of EDIS Program:

1. Child / Family Information

Child's Name: (last, first, middle initial)	Today's Date: (DD MMM YYYY)
Parent/Guardian Name: (last, first, middle initial)	

2. Information ☐ **Request** ☐ **Release**
(check one box only - separate consent forms are required for each action)

The following written/verbal information will be requested from or released to the designated individuals/agencies for use in assisting with the assessment and implementation of early intervention services for your child.

☐ Developmental Evaluations ☐ Hearing Evaluations

☐ Individualized Family Service Plan (IFSP) ☐ Vision Evaluations

☐ Medical records pertaining to the following specific evaluations or diagnosis:

☐ Other: (Describe the specific information to be shared, e.g., progress summaries, discharge summary, equipment requirements, discussion of child's progress with day care provider. Avoid non-specific statements such as "child's cumulative file.")

3. Sources of Information

Information from:	Information to:
Name of Individual/Agency:	Name of Individual/Agency:
Attention:	Attention:
Address	Address
City State ZIP	City State ZIP

4. Parent / Guardian Consent

Privacy Act Statement: 20 USC Chapter 33 (Individuals with Disabilities Education Act) authorizes collection of this information. My signature below indicates consent to request/release information as indicated above between the designated individuals/agencies. I understand this information will be kept confidential, used for the provision of services to my child and family and added to my child's EDIS record. I may revoke this authorization at any time. The revocation must be in writing and provided to the facility where my child's medical records are kept. I am aware that if I later revoke this authorization, the individuals/agencies indicated above will have used and/or disclosed my child's protected health information on the basis of this authorization. If I authorize disclosure of my child's protected health information to someone who is not required to comply with Federal privacy regulations, then such information may be re-disclosed and would no longer be protected. I have a right to inspect and receive a copy of my child's protected health information for use/disclosure in accordance with Federal privacy regulations found in the Privacy Act and 45 CFR 164.524.

Parent/Guardian: (Signature and Date)	Parent/Guardian: (Signature and Date)

Prepared by: (Name, Title, Signature and Date of EDIS Staff Member)

Original: EDIS Convenience Record **- Copy:** Parent