Release/Exchange of Confidential Mental Health Information

Child's Name			
Last:	First:	Middle:	Date of Birth:
Parent/Guardian Name(s):			

Head Start/ECEAP Program	Agency / Individual
Center:	Name:
Site:	Agency:
Address:	Address:
City: St: Zip:	City: St: Zip:
Phone:	Phone:
Fax:	Fax:

Authorization

Information to be Disclosed / Exchanged:

- ❑ Birth and Developmental History
- ❑ School / Classroom Issues
- ❑ Family History / Information
- ❑ Health / Medical Issues
- ❑ Other (please specify):_____
- ❑ Other (please specify): _____
- ❑ Developmental Screening / Assessment
- ❑ Legal Issues
- ❑ Abuse / Neglect
- ❑ Domestic Violence

Reason for Disclosure:

- ❑ Assist in Assessment and Treatment
- ❑ Assist in Referral
- ❑ Coordination of Care
- ❑ Other (please specify): _____

I authorize the disclosure and exchange of information between Puget Sound ESD and the above-named agency/individual.

This permission is valid for: Current School Year, or Until date or event (please specify): _____

I may revoke or withdraw my permission in writing at any time, but that will not affect information already disclosed.

I understand that these records will be treated as confidential by the Head Start/ECEAP program.

A copy of this form is valid to give permission to disclose records.

Signature:	Date signed:
Print Name:	Phone:
Address:	
Relationship to Child:	Interpreter (sign and print name, if applicable):