Release/Exchange of Confidential Mental Health Information

Authorization to Disclose Records Of:			
Child's Name Last	First	Middle	**Date of Birth**
Parent/Guardian Name(s)			

Information Released From: (Early Learning Staff complete this section)		
Site/Program Name		
Address		
Phone Number	**Fax Number**	**E-mail**

Information to be Released To:

Agency/Individual: _____

Address: _____

_____

Phone Number: **Fax:**

Information to be Disclosed/Exchanged:

- ☐Birth and developmental history
- ☐School/classroom issues
- ☐Family history/information
- ☐Health/medical issues
- ☐Developmental screening/assessment
- ☐Legal issues
- ☐Abuse/neglect
- ☐Domestic violence
- ☐Other – Please specify:

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 the Early Learning Program and the above-named agency/individual.

This permission is valid for: ☐Current school year or ☐until _____
(date or event)

- *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 Early Learning Program. A copy of this form is valid to give permission to disclose records.*

Authorization by: Signature		Print Name
Date	**Phone Number**	**Relationship to Child**
Address		
Interpreter Name and Signature (if applicable)		