

Release/Exchange of Confidential Information (Non Health)

Non-Health Information Only
(IEP/IFSP information, records for transfers/transitions, etc.)

Child's Name _____ Date of Birth _____

Other identifying information that may help in locating records (ID #, case #, etc.): _____

Center/Site _____ Phone _____

Address _____

As the adult in this family OR the parent/guardian of the above-named child, I authorize the mutual exchange of confidential information between Puget Sound ESD Early Learning programs and

Agency, Individual, or Local School District _____

Address _____

Information to be exchanged _____

Reason for exchange of information _____

Parent/Guardian Signature _____ Date _____

Staff Signature _____ Date _____

Interpreter Signature (if applicable) _____ Date _____

In accordance with the requirements of the Family Educational Rights and Privacy Act of 1974, and the Puget Sound ESD Early Learning Confidentiality Policy, information sent or received by PSESD Early Learning may not be shared with any other party without the written consent of the parents or guardian.

This consent is valid for 12 months from date of parent/guardian signature.
An [Authorization to Release Confidential Health Information](#) form or [Release/Exchange of Confidential Mental Health Information](#) form must be used for the exchange of any health-related or mental health-related information.