AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

CHILD: _____ _____ _____ _____ _____
Last First Middle ID: DOB:

PARENT /LEGAL GUARDIAN: _____ _____ _____ _____
Last First Middle Phone#

I have checked the boxes and provided my signature below for the agencies/providers for which I have given permission to ☐ disclose and/or ☐ obtain information for the purposes of improving the well being of my child named above via mail, phone, fax, video, or secure encrypted email. I understand the following:

- That information may be disclosed to parties not listed below as required for billing and access to services and continuity of care.
- Only the minimum amount of information necessary to fulfill a request will be released/obtained.
- There may be a charge per page, plus postage and handling, for copy services unless copies are provided directly to an entity for the purposes of continuity of care.

☐ Children's Medical Services Program(s)
☐ Local Education Agency/School System
☐ Head Start/Early Head Start
☐ Florida Diagnostic& Learning Resources System (FDLRS/child find)
☐ Office of Disability Determinations (SSI)
☐ Parent/Legal Guardian
☐ Children and Families Voluntary Family Services
☐ Department of Health Birth Defects Registry
☐ Department of Education
☐ Department of Health Newborn Screening Program
☐ Medicaid/ Managed Care Plan _____ Name _____ Phone
☐ Pediatrician/Physician _____ Name _____ Phone
☒ Other Primary Service Provider Team Name _____ Phone
☐ Hospital _____ Name _____ Phone

INFORMATION TO BE DISCLOSED/OBTAINED: (check selection)

☐ General Medical Record(s) ☐ Progress Notes ☐ History and Physical Results, including diagnostic information
☐ Immunizations ☐ Consultations ☐ Individualized Family Support Plan/Evaluation/Assessment Reports
☒ Other: (specify) Children's Services Council St. Lucie County to research, track and measure child outcomes for CSC funded programs. (772) 408-1100

I specifically authorize release of information relating to: (check selection if applicable)

☐ HIV test results for non-treatment purposes ☐ Substance Abuse Service Provider Client Records ☐ Mental Health notes

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

RE-DISCLOSURE: I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that services will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to my service coordinator. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____

PARENT/LEGAL GUARDIAN: Signature Date

Consent reviewed and authorization obtained via telemedicine. Verbal consent provided by family.