CHILD AND FAMILY CONNECTIONS
CONSENT FOR RELEASE OF INFORMATION FOR CHILDREN WITH IDENTIFIED HEARING LOSS

NOTE: This form is only completed for children with an identified hearing loss and is completed at the time of the initial Individualized Family Service Plan (IFSP) meeting **or** any time after the initial IFSP meeting that an identified hearing loss is confirmed **or** if the family of a child with an identified hearing loss chooses not to accept services from the Illinois Early Intervention (EI) Program.

I/We ________________________________ give my/our informed consent for:
Printed Parent/Legal Guardian Name(s)

____
Name of Service Coordinator | CFC # | Phone #

____
Street Address/Post Office Box | City/Town | State | Zip Code

____
Name of Child's Audiologist | Phone #

To inform the Illinois Department of Public Health, Newborn Hearing Screening Program by transmission of this form that:

☐ An IFSP was completed on____________________for my child;
Date

☐ An identified hearing loss was confirmed and services were added to my child's IFSP on ____________________or
Date

☐ My child has an identified hearing loss but I choose not to accept EI services.

______________________ ______________________ ______________________
Child's Legal Name (First & Last) | Date of Birth | Other name child known as

______________________ ______________________
Street Address/Post Office Box | Hospital child born in

______________________ ______________________ ______________________
City/Town | State | Zip Code

The Illinois Department of Public Health (IDPH) will use this information to confirm that my child will receive services through the State of Illinois' Bureau of EI or that I have chosen not to accept services from EI. IDPH will not further disclose this information without my prior written consent and will use it only for the preparation of management or statistical reports. This information is needed to evaluate the State of Illinois' Newborn Hearing Screening Program.

This consent is valid for 365 days following the date of my signature on this form. I understand that my consent is voluntary and that I may withdraw this consent by written request to the CFC above at any time, except to the extent that it has already been acted upon. I understand that my refusal to consent to the disclosure of this information will have no effect on the delivery of EI services to my child; however will inhibit effective evaluation of the State's Newborn Hearing Screening Program.

I HAVE READ AND UNDERSTAND THE CONDITIONS OF THIS FORM.

______________________________________ ______________________
Signature (Parent/Legal Guardian) | Date

______________________________________ ______________________
Witness | Date

Notice to Receiving Agency/Person
Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Family Educational Rights and Privacy Act, 20 USC 1232g, and the Health Insurance Portability and Accountability Act of 1996, information collected hereunder may not be redisclosed unless the person who consented to this disclosure specifically consents to such redisclosure or the redisclosure is allowed by law.

Send this information to:
Administrator IDPH - Genetics/Newborn Screening 535 West Jefferson, 2nd Floor Springfield, IL 62761 Phone: 217/785-8101 Fax: 217/557-5324