

**CHILD AND FAMILY CONNECTIONS
 CONSENT FOR RELEASE OF INFORMATION**

Child's Last Name, First Name & Middle Initial _____
 Child's Date of Birth (Month/Day/Year) _____
 Cornerstone Participant ID # _____ CBO/EI # _____

I authorize the Child and Family Connections (CFC) office to release/obtain the information below: **TO** **FROM**
 Name: _____
 Address: _____
 City, State & Zip: _____

Specific Information to be Disclosed if Available

Obtain	Release	Type of Information	Description (timeframe, date of service)
<input type="checkbox"/>	<input type="checkbox"/>	Developmental Reports	
<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy Reports	
<input type="checkbox"/>	<input type="checkbox"/>	Physical Therapy Reports	
<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language Reports	
<input type="checkbox"/>	<input type="checkbox"/>	Audiological Reports	
<input type="checkbox"/>	<input type="checkbox"/>	Vision Reports	
<input type="checkbox"/>	<input type="checkbox"/>	Medical Reports, Diagnosis, Prescriptions	
<input type="checkbox"/>	<input type="checkbox"/>	Program Eligibility & Financial Status	
<input type="checkbox"/>	<input type="checkbox"/>	Eligibility Information to Referral Source	
<input type="checkbox"/>	<input type="checkbox"/>	Other	

This information is needed for the following purpose(s): (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Establish Early Intervention (EI) eligibility | <input type="checkbox"/> Coordinate, monitor and implement EI services |
| <input type="checkbox"/> Develop an Individualized Family Service Plan (IFSP) | <input type="checkbox"/> Facilitate transition |
| <input type="checkbox"/> Treatment, payment, healthcare operations | <input type="checkbox"/> Other: _____ |

This consent for disclosure is valid until: _____ / _____ / _____
 Month Day Year

I understand that I have the right to inspect and copy the information to be disclosed. 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 disclosure will have the following consequences, if any: Inability to establish EI eligibility; develop an IFSP; coordinate, monitor and implement services; or facilitate transition.

Other consequences: _____

Parent/Guardian/Surroogate Printed Name: _____
 Parent/Guardian/Surrogate Signature: _____ Date _____
 Witness Signature: _____ Date _____

Notice to Receiving Agency/Person:	Send Information to: (enter name and address)
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.	Name: _____
	Office Name: _____
	Address: _____
	City: _____ State: _____ Zip Code: _____