Practice Name/Logo & Address here

**Consent to Share/Release Information with CDSA and Schools**

Age or Grade

Teacher/ Preschool Coordinator/CDSA Contact

School, School System, or CDSA

 Patient Name Date of Birth Chart Number

This release has been explained to me. I understand what information is to be released and why. I also understand that there are laws that protect my privacy. I understand that I may cancel this release at any time except when action has been taken based on this consent. I, hereby, give my permission to the **Agency/Facility** named to exchange information as described below. I also give permission for medical records listed below to be released to the requesting **Agency/Facility**. This consent is valid for one year from the date signed.

Signature Date Phone (Circle one – Patient, Parent or Legal Guardian)

Street Address City State Witness Title Date

**Information to be exchanged (Please circle below)**

Physical/Medical Information, Home Health Records, Hospital Records; Mental Health (Psychological/Psychiatric),

Emotional, Behavioral, Developmental, and/or Educational screenings/evaluation(s), Audiological and Vision screening results

**Medical Home Feedback Form**: Established Conditions, Conditions that Adversely Impact Educational Performance CDSA/Preschool Program eligibility determination results, services provided on the IEP/IFSP, Recommended additional community services.

Other: \_ Agencies Exchanging Information:

Fax

Phone

Attention:

Fax

Phone

Attention

**Medical Records Dept.\_**

Zip

State

City

Zip

State

City

Mailing Address

Mailing Address

**Name of Medical Practice:**

**Name of County Schools\_/ CDSA/ Community Agency:**

***Two way release for Medical Home and CDSA/School January 2015***