Social Health and Early Childhood Well-being

EQIPP
Helping You Improve Care for Children
Available on PediaLink

Consent to Share/Release Information with Community Partner or Agency

Patient Name _____ Date of Birth _____ Chart Number _____

Community Partner or Agency _____ Partner or Agency Contact _____ Age or Grade _____

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 Part C/Preschool Program eligibility determination results, services provided on, Recommended additional community services.

Other:_____

Agencies Exchanging Information:

Name of Community Partner or Agency:	**Name of Medical Practice:**
Mailing Address	Mailing Address
City State Zip	City State Zip
Attention Phone Fax	**Medical Records Dept.** Attention: Phone Fax

Two-way release for Medical Home and Community Partner or Agency

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™