CONSENT FOR EXCHANGE OF INFORMATION

I hereby authorize (Agency) _____

(Address)_____
to exchange information

about my child _____ Date of Birth _____

with (Clinician) _____

(Address)_____.

Please exchange the following types of information (check all that you approve):

_____ questionnaires
_____ academic records

_____ medical records
_____ mental health records
_____ developmental testing/assessments
_____ other (specify)

I understand that:

- this authorization is aimed at assisting my child's doctor in helping my child.
- this authorization is voluntary.
- my child's treatment will not change if I do not agree to this.
- the only risk is loss of confidentiality. I also understand that the computer system being used by the teacher to answer questions about my child is secure.
- my child's records are protected as confidential under Federal law.
- I may revoke this consent at any time except to the extent that action has been taken on it (e.g., already communicated).
- this consent automatically expires in one year, if my child changes doctor or if my child is no longer cared for by this agency.
- that I may copy this form and that I may request a copy of the information provided.

_____ _____
Parent or guardian name printed Signature

Today's date: __ __ /___ ___ /___ ___ _____
Month Day Year Witness