

**Next Step Clinic Agreement for Release of Information**

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| **1** | **I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name), hereby agree**:  |
| **2**  | □ **To release information to**: □**To obtain information from**:*(Check one box or both. By checking both, you are allowing an exchange of information between the agencies/individuals listed.)*Agency and/or individual\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street/City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **3** | **From the records of**:Client name\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other names used\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **4** | **Purpose or need for sharing**: *(check all that apply)*□ Service coordination □ Evaluation/Diagnosis □ Treatment □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **5** | **Types of information to be shared**: *(check all that apply)*□ Developmental Disabilities □ Medical □ Human Services □ Educational □ Other *(specify)***Specific** information to be shared: *(check all that apply)*□ Developmental Monitoring □ Developmental Screenings □ Intake Summary □ Contact Information □ Other *(specify*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **6** | **I understand that**:*(a) The information released is confidential and protected from further sharing.* *(b) I have the right to cancel my agreement to release information at any time.**(c) I am not required to sign this form and may refuse to do so**I hereby authorize the periodic release of the above information to the person/organization/facility/program identified above as often as necessary to plan for, provide care, services and treatment.* |
| **7** | **This consent (unless cancelled earlier) expires on**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, one year from the date signed, or 60 days following my discharge or withdrawal from services, whichever occurs first. |
| **8** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent or Guardian Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Witness Signature Date |

 – A PHOTOCOPY, FAX OR ELECTRONIC IMAGE OF THIS CONSENT SHALL BE AS VALID AS THE ORIGINAL –