



Early On Authorization to Share Information

Child's Name: Last	First	Middle
Birth Date:	Parent/Guardian/Surrogate Parent:	
<p><i>Early On</i> Michigan helps to coordinate services that eligible children may need to grow and develop. I understand that these services may come from different agencies. In order to plan for and provide the best possible care for my child and our family, various professionals may need to share information about my child. This form is an authorization, or permission from me, for those professionals to share the information I would like shared. I understand that this information may be used to help decide if my child is eligible for services, how best to coordinate and provide those services, and the services for which we qualify.</p> <p>The agencies and persons I have initialed below have my permission to share the information about my child and family that I have listed. This could be electronic, verbal, or written. I understand that information will NOT be shared without my authorization with anyone who does not have a valid reason for it or unless authorized under applicable federal and state laws. I understand that this information will not be shared with anyone who has not agreed to meet applicable confidentiality standards. I am aware that I can, without penalty, at any time, cancel this consent and not share information with these persons or agencies. My authorization to share information is voluntary and is good for six (6) months. At any time I may let <i>Early On</i> know, in writing, that I wish to cancel this authorization to share information form.</p> <p>I understand that <i>Early On</i> needs my feedback in order to plan improvements for eligible children and their families, and that my name and address may be used by <i>Early On</i> to send me <i>Early On</i> consumer surveys.</p> <p>Please initial all lines that apply:</p> <p><input type="checkbox"/> I have read and understand this consent form (or it has been read to me in a language I understand).</p> <p><input type="checkbox"/> I understand that my authorization or consent to allow the sharing of information about my child is voluntary and I may deny or revoke consent at any time, without penalty. Revocation of consent is not retroactive.</p> <p><input type="checkbox"/> I understand that information about my child will also be kept on a database that is subject to the same confidentiality provisions.</p> <p><input type="checkbox"/> I understand the confidentiality of information about my child is protected by state and federal law, including the Individuals with Disabilities Education Act (IDEA), the Family Educational Rights and Privacy Act (FERPA), and the Health Insurance Portability and Accountability Act (HIPAA). The protected health information (PHI) or personally-identifiable information (PII) in my child's records cannot be disclosed, given, sold, or transferred in any way to any other agency/program (and its contractors or authorized representatives) not specified in this release unless otherwise specifically authorized by federal or state laws.</p> <p><input type="checkbox"/> I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or services, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.</p> <p><input type="checkbox"/> I authorize the agencies designated and their contractees or representatives to engage in verbal or written communication in order to share records and information as indicated above.</p> <p>OR</p> <p><input type="checkbox"/> I do not wish to have any information shared at this time.</p>		

Child's Name: Last	First	Middle
Birth Date:		Parent/Guardian/Surrogate Parent:

Agencies Authorized to Exchange Information Include: (initial those that apply)

Info to share	Initial	Agency/Person	Info to share	Initial	Agency/Person
		Health Department (specify)			Head Start
		Community Mental Health (specify)			Hospital (specify)
		Department of Human Services			Physician (specify)
		Intermediate School District (specify)			Physician (specify)
		Local School District (specify)			Other (specify)
		Michigan Department of Community Health			Other (specify)

Parent/Guardian:	Date:	Expiration Date: (6 months after signature)
------------------	-------	--

Service Coordinator/Witness:	Date:
------------------------------	-------

To withdraw consent: check the box below and sign.
 I withdraw my consent for persons/agencies to share information as listed above. I understand that my withdrawal is not retroactive so that information shared before my withdrawal is still considered authorized.

Signature of Parent/Guardian:	Date:
-------------------------------	-------

NOTE: This form may also include information about behavioral or mental health services. This form does not permit information about HIV/AIDS, other communicable diseases, and federally-funded programs on drug and/or alcohol use/misuse to be shared. A separate authorization to share, specific to this information, must be obtained and signed.
 I understand that certain directory or child find information (which is the child and parents' names, child's date of birth, address(es), and phone numbers) may be disclosed to the school district for purposes of contacting parents about potential preschool services, but that the school district may not re-disclose this information to others without prior written parental consent under IDEA and FERPA.

6 Month Reauthorization	Date: _____	Parent/Guardian: _____	Service Coordinator: _____
6 Month Reauthorization	Date: _____	Parent/Guardian: _____	Service Coordinator: _____
6 Month Reauthorization	Date: _____	Parent/Guardian: _____	Service Coordinator: _____
6 Month Reauthorization	Date: _____	Parent/Guardian: _____	Service Coordinator: _____
6 Month Reauthorization	Date: _____	Parent/Guardian: _____	Service Coordinator: _____

Information Codes		
(1) Educational Records inc. any IEPs of/from ISD and LSD	(6) Social/Developmental History	(10)(A) Occupational Therapy Reports
(2) Health/Medical Reports	(7) Staffing Reports/ Provider Notes	(10)(B) Physical Therapy Reports
(3) Progress Reports	(8) Speech/Language/ Communication Reports	(11) IFSP Service Plan (parent-signed Initial and any subsequent signed IFSPs)
(4) Discharge Summaries	(9) Developmental Evaluations and Assessments	(12) Medicaid Number (This will also be used to access information associated with the number that is needed to ensure diagnosis, treatment and payment of services.)
		(13) Private Insurance Number (This will also be used to access information associated with the number that is needed to ensure diagnosis, treatment and payment of services.)
		(17) All Information
(5) Psychological Reports	(10) Gross/Fine Motor Reports [OT and PT reports are a subset of this category]	(18) Other (specify)