



Consent for Release of Information and Referral

from Child Care Health Consultant and/or Child Care Program to Other Individuals/Programs/Agencies

I understand that information regarding my child is generally confidential and may not be given to employees of other schools, public agencies or individual professionals in private practice without my consent or other legal requirement.

Consent for Release of Information

I, _____, hereby consent to the release of the following information

FULL NAME OF PARENT/GUARDIAN

initialed and checked below, regarding my child _____ held by

FULL NAME OF CHILD

_____ to _____.

FULL NAME OF INDIVIDUAL OR AGENCY/ADDRESS

FULL NAME OF CHILD CARE HEALTH CONSULTANT

Educational/Developmental Records

INITIAL

Diagnostic Assessments/Evaluations (OCCUPATIONAL/PHYSICAL THERAPY, SPEECH AND LANGUAGE PATHOLOGY, PSYCHOLOGICAL, SOCIAL-EMOTIONAL)

INITIAL

Developmental/Health Screening(s): _____

INITIAL

PLEASE SPECIFY

Medical Dental Immunization Records

INITIAL

INITIAL

INITIAL

Other: _____

INITIAL

PLEASE SPECIFY:

Consent for Referral

I also authorize communication and exchange of information between: _____

NAME OF INDIVIDUAL/AGENCY HOLDING RECORDS

and/or: _____ and _____.

NAME OF CHILD CARE HEALTH CONSULTANT

NAME OF CHILD CARE PROGRAM

Further, _____ is authorized to share the information gained with

NAME OF CHILD CARE HEALTH CONSULTANT

his/her supervisor(s) and/or child care health consulting staff working directly with her/him. Consent for release of information and authorization of communication shall be for the limited purpose of understanding and addressing my child's needs.

This consent is voluntary and I understand that I can withdraw my consent for my child at any time. Unless I withdraw this consent, this authorization will be effective for the period my child is continuously enrolled in the _____.

NAME OF CHILD CARE PROGRAM

By signing below, I am confirming that I have read, understood and agree to the above.

Name: _____ **Signature:** _____ **Date:** _____

PRINT FULL PARENT/GUARDIAN NAME

PARENT/GUARDIAN SIGNATURE:

NOTE: IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND APPLICABLE CALIFORNIA LAWS, ALL PERSONAL AND HEALTH INFORMATION IS PRIVATE AND MUST BE PROTECTED.

California Childcare Health Program • School of Nursing, University of California, San Francisco (UCSF)
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