

**Authorization to Release & Exchange Information**

Child:       Date of Birth:      /     /

On behalf of the above named child, I agree to the **Release and Exchange** of information (written, verbal, electronic) between the following entities:

|  |  |
| --- | --- |
| Agency:  Agency Contact: | Agency:  Agency Contact: |
| Address:  City     , State     , Zip:  Email: | Address:  City     , State     , Zip:  Email: |
| Phone: (     )     - | Phone: (     )     - |

Information may be shared in the areas indicated: (select all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Minimum necessary or specify: | | | |
|  | Most recent medical/health history and physical or Specify Dates: |  | Most recent evaluation and/or report (including Early ACCESS evaluation/assessment report) |
|  | Most recent admission & discharge Summary or Specify Dates: |  | X-Ray and imaging reports |
|  | Consultation Reports |  | Medications |
|  | Most recent Individualized Family Service Plan (including services and outcomes) |  | Other – Specify: |

I understand information in the following areas may not be released without my specific permission. My signature will serve as my special consent for the exchange of information in the areas indicated: (select all that apply)

Mental health  Substance abuse/chemical dependence

HIV/AIDS  Genetic Test/Information of future health issues

I understand that I have the following **rights** with respect to this Authorization:

* The right to receive a copy of this form.
* The right to inspect or copy the educational and health information to be disclosed by this form.
* The right to withdraw this Authorization by written notification at any time; although my withdrawal will not affect the use of information shared prior to the request for revocation.
* Eligibility determination and services provided under Early ACCESS are not conditioned on signing of this Authorization.

I also acknowledge my awareness of:

* Recipients of this information may possibly re-release the information without proper authorization, and
* Once information is disclosed it may no longer be protected by federal privacy regulations.

Individuals from Early ACCESS agencies who are serving this child and family, and those identified as having a legitimate educational interest, may review this information.

This Authorization is valid until the child’s third birthday, or until the date of:      /     /     , whichever occurs first.

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Parent/Guardian Signature Relationship to child Date

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Printed Name

**Family Educational Rights and Privacy Act (FERPA) / Health Insurance Portability and Accountability Act (HIPAA) Notice**

Any and all personally identifiable information regarding children and families receiving Early ACCESS services funded under the Individuals with Disabilities Education Act (20 U.S.C. §1400 et seq.) is protected from unauthorized disclosure under FERPA. Personally identifiable information protected by FERPA is specifically exempted from HIPAA privacy standards. FERPA prohibits disclosure of personally identifiable information without parent consent except in limited circumstances, requires notice to be provided to the child’s family regarding their privacy rights, requires providers to keep records of access to a child’s records, and contains complaint and appeal procedures which apply to disputes over records in possession of Early ACCESS or its providers, among other provisions. All Early ACCESS providers comply with these procedures

**NOTICE TO RECIPIENTS OF MENTAL HEALTH INFORMATION**

In accordance with the Iowa Mental Health Information Disclosure Act (Iowa Code § 228), a recipient of mental health information may disclose this information only with the written authorization of the subject or the subject's legal representative or as otherwise provided in chapter 228. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply.

**NOTICE TO RECIPIENTS OF SUBSTANCE ABUSE INFORMATION**

This information has been disclosed from records whose confidentiality is protected by Federal law. Iowa Code, Chapter 125 and Federal regulations (42 CFR, § 2) prohibit any further disclosure without the specific written consent of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**NOTICE TO RECIPIENT OF HIV RELATED TESTING INFORMATION**

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. (Iowa Code § 141A.9. Federal confidentiality rules (42 CFR, § 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.