

**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 –