pennsylvania
OFFICE OF CHILD DEVELOPMENT AND EARLY LEARNING

Bureau of Early Intervention Services & Family Supports

Authorization to Release Information for Infants/Toddlers with Hearing Concerns

Welcome to Early Intervention! **This form is very important to make sure we all work together for children who are deaf or hard of hearing.**

The Bureau of Early Intervention Services & Family Supports works closely with the Pennsylvania Department of Health to provide supports and services to children and families of children with hearing concerns. It is very important that we provide information to the Department of Health to let them know that your child **has reached Early Intervention services**. This will help Pennsylvania to continue to provide supports and services to children with hearing concerns.

SECTION 1.

Parent/Guardian _____

Mailing Address _____

Email Address _____ Daytime Phone _____

Child's Full Name _____

Child's Date of Birth _____

Mother's Name at Birth of Child _____

Birth Hospital _____

Audiologist's Name _____

Audiologist's Phone Number _____

SECTION 2.

_____ **(initial**) I consent to sharing the information in **SECTION 1** above and the date of my child's referral to Early Intervention, date of evaluation and date of IFSP with the PA Department of Health. No other information is shared.
_____ **(initial**) I would like contact from a Parent Mentor to learn more about Family Connections: Language and Learning for Children who are Deaf/Hard of Hearing, an Affiliate Program of Parent to Parent of PA.

As the parent/guardian of the minor child, I voluntarily provide consent for the PA Department of Health to receive the information in **SECTION 1** above and the date of my child's referral to Early Intervention, date of evaluation and date of IFSP. I understand the Department of Health will keep the information about my child and family in a confidential manner. I understand that:

1) I am providing my consent voluntarily and I understand the information on this form and
2) I have the right to withdraw my consent at any time; and
3) I have the right to inspect and copy the information to be shared.

Unless otherwise stated, this release is valid for one year from the date signed. The information shared will not be further or re-disclosed to anyone else without written consent of the parent/guardian.

Signature of Parent/Guardian _____ Date _____
Relationship to Child _____

Please return completed form to: Bureau of Early Intervention Services & Family Supports (BEIS/FS)
333 Market Street, 6th Floor, Harrisburg, PA 17126 - Email: RA-ocdintervention@pa.gov - Fax: 717.346.9330

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