

**MATERNAL CHILD HEALTH SERVICES
HOOSIER HEALTHWISE
FIRST STEPS EARLY INTERVENTION SYSTEM
CHILDREN'S SPECIAL HEALTH CARE SERVICES
CONSENT TO RELEASE AND SHARE MEDICAL INFORMATION**

PLEASE REVIEW THE INFORMATION ON THE REVERSE SIDE OF THIS FORM, AND HAVE YOUR INTAKE/SERVICE COORDINATOR DISCUSS ANY QUESTIONS THAT YOU MAY HAVE BEFORE SIGNING BELOW.

I/We, _____ give my/our informed consent for
Parent/Legal Guardian Name(s)

Physician/Health/Medical Care Provider or Facility Name

Practice/Hospital (as applicable)

Street Address/Post Office

City/Town State Zip Code

To communicate and to share information, in writing and conversation, with the First Steps Early Intervention Service System and Children's Special Health Care Services regarding:

Child's Legal Name Date of Birth

Street Address/Post Office

City/Town State Zip Code

This Consent includes the following types of information: (as checked)

- _____ Medical record information including but not limited to: progress notes, laboratory and x-ray reports, history and physical, discharge summary and treatment plan(s)
- _____ Written specialty reports including assessments
- _____ The Individualized Family Service Plan (IFSP)
- _____ Progress reports
- _____ Correspondence and other communication regarding eligibility and/or the provision of early intervention services and/or special health care services
- _____ Medical record information required to determine eligibility, participate in service planning, and/or provide early intervention services as defined in the Individualized Family Service Plan (IFSP)

I HAVE READ AND UNDERSTAND THE CONDITIONS OF THIS RELEASE, AS CONTAINED ON THE REVERSE SIDE OF THIS FORM.

Signature (Participant if over 18 years of age)

Date

Signature (Parent/Legal Guardian) (Surrogate Parent for education only)

Date

Witness

Date

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*PLEASE READ THIS CAREFULLY BEFORE SIGNING.
IF YOU HAVE QUESTIONS, PLEASE ASK YOUR SERVICE/CARE COORDINATOR*

The purpose of this release is to collect information necessary to determine the participant's eligibility for the programs listed above, and to plan and provide essential and necessary services as determined through the multidisciplinary team process. I hereby authorize the medical provider named on this form to release to the staff of Maternal Child Health Services, and/or Hoosier Healthwise, and/or First Steps and/or Children's Special Health Care Services upon presentation of this form, any records or information pertinent to the development and implementation of a plan for service to meet the medical, educational, developmental, social and rehabilitative needs for the participant named on this form. Authorization is also granted for release of information by Maternal Child Health Services, and/or Hoosier Healthwise, and/or First Steps and/or Children's Special Health Care Services to accomplish referrals for service to other individuals where an informed, written consent has been obtained from me as the parent/legal guardian; and to ensure ongoing service delivery in accordance with the IFSP through routine communications including report distribution, participation in IFSP meetings, and planning and review activities.

I understand that this consent includes the sharing of information as authorized above in written, verbal, and/or video format. As the parent/legal guardian, or surrogate parent (for educational purposes only, in the event one is appointed for early intervention services). I understand that I may revoke this authorization shown on the reverse of this form at any time in writing. The request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first. A copy of this authorization has the same effect as an original.

The information collected as a result of this consent shall be maintained in the participant's record which will be located at Maternal Child Health Services, and/or the Indiana Family Social Services Administration Hoosier Healthwise, and/or First Steps, and/or Children's Special Health Care Services the Indiana State Department of Health. This record is subject to the provisions of the Family Educational Rights and Privacy Act (FERPA) and Release of Medical Records Law I.C. 16-39-1, as such, is available for my review and may be reproduced or corrected upon my request. All personal information collected will be treated as confidential pursuant to I.C. 4-1-6 et seq, I.C. 5-14-3-4 and 410, IAC 3.2-10.