Informed Consent for Services and Exchange of Information

Child's Name: ___________________________ D.O.B: ________________________

Insurance: ______________________________ Insurance #: ____________________

Parent's Name: ____

Phone: _________________________________ Date: __________________________

I, ______________________ (Parent/Guardian's Name) hereby give permission for my child, _________________, to receive the following services through The Early Learning Coalition of Pasco and Hernando Counties, Inc.: (Please initial each one):

_____Observation _____Screenings _____ Assessment/Testing

I, ___________________________ (Parent/Guardian's Name) hereby give permission for The Early Learning Coalition of Pasco and Hernando Counties, Inc. (PHELC) to release and obtain student records, health and other confidential information and other Health Information, from other agencies or providers (see list below) as the term is defined in the Privacy Rule of the Health Insurance Portability and Accountability Act, of my child, _________________________.

The agencies and programs that this release covers are: FDLRS, Baycare, EarlySteps, Independent Living, Inc., Lifespan, and the childcare provider.

Further, I also give consent to PHELC and the above identified agencies and/or programs to communicate with each other regarding my child.

I have read this Informed Consent and Release and understand its terms. I sign it voluntarily and with full knowledge of its significance.

_________________________________ ____________________

Parent/Legal Guardian's Signature Date

_________________________________ ____________________

Director Signature Date