|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *North Carolina Infant-Toddler Program* | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| *Authorization to Disclose Health Information* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child’s Name: | | |  | | | | | | | | | | | | | | | Date of Birth: | | | | |  | | | |
| Child’s Medical Record #: | | | | |  | | | | | | | | | | | | |  | | | | |  | | | |
| I, |  | | | | | | | | | | | | Hereby authorize | | | | | | |  | | | | | | |
| *(Parent/Legal Guardian or Personal Representative)* | | | | | | | | | | | | | | | | | *(Name of Provider/Agency/Individual)* | | | | | | | | | |
| To disclose and exchange specific health information from the records (verbal, written and/or electronic) of the above-named child to/from | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  |  | | | | | | | | | | |  | |  | | |  |  |
| *Recipient(s) Name* | | | | | | | |  | *Address* | | | | | | | | | | |  | | *Phone* | | |  | *Fax (optional)* |
|  | | | | | | | |  |  | | | | | | | | | | |  | |  | | |  |  |
| *Recipient(s) Name* | | | | | | | |  | *Address* | | | | | | | | | | |  | | *Phone* | | |  | *Fax (optional)* |
|  | | | | | | | |  |  | | | | | | | | | | |  | |  | | |  |  |
| *Recipient(s) Name* | | | | | | | |  | *Address* | | | | | | | | | | |  | | *Phone* | | |  | *Fax (optional)* |
| For the following purpose(s): | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Specific information to be disclosed/exchanged (check all that apply): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Birth Records/History | | | | | | | Physical Therapy Evaluations | | | | | Multidisciplinary Evaluations | | | | | | | | | | | | | | |
| Health and Medical Records | | | | | | | Occupational Therapy Evaluations | | | | | Individualized Family Service Plans [IFSPs] | | | | | | | | | | | | | | |
| Laboratory Results | | | | | | | Speech and Language Evaluations | | | | | Status of Eligibility | | | | | | | | | | | | | | |
| Admission/Discharge Summaries | | | | | | | Developmental Assessments | | | | | Progress Reports/Progress Notes | | | | | | | | | | | | | | |
| Ophthalmological Evaluations | | | | | | | Nutritional Assessments | | | | | Other [specify] | | | | | | | | |  | | | | | |
| Audiological Evaluations | | | | | | | Educational Evaluations | | | | | Other [specify] | | | | | | | | |  | | | | | |
| Social History | | | | | | | Psychological Evaluations | | | | | Other [specify] | | | | | | | | |  | | | | | |
| Developmental History | | | | | | | Medical Evaluations | | | | | RESTRICTIONS See Specific Request | | | | | | | | | | | | | | |
| I understand that this authorization will expire on the following date, event, or condition: | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| **(NOT TO EXCEED ONE YEAR)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time by signing the *Revocation Section* on the bottom of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.  I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.  I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure may include that information. I understand that I may request that the disclosure of this information be restricted. I also understand that I may refuse to sign this authorization. I also understand that the Infant Toddler Program cannot deny or refuse to provide treatment or eligibility of benefits if I refuse to sign this authorization. (Note, however, if treatment is research related, treatment may be denied if authorization is not given.)  I further understand that I will receive a copy of this signed authorization. | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | |  | | | | |  | |  | | | | | |
| *Signature of Parent, Client, Legal Guardian, Personal Representative* | | | | | | | | | | |  | | | *Date* | | | | |  | | *Relationship/Authority* | | | | | |
|  | | | | | | | | | | |  | | |  | | | | |  | |  | | | | | |
| *Signature of Witness* | | | | | | | | | | |  | | | *Date* | | | | |  | | *Relationship/Authority* | | | | | |
| |  | | --- | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **AUTHORIZATION TO DISCLOSE HEALTH INFORMATION – REVOCATION SECTION** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I do hereby request that this authorization to exchange/ disclose health information of | | | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | *Child’s Name* | | | | | | | | | | |
| Signed by: | |  | | | | | | | | | | | | | | | | | On |  | | | | | | |
|  | | *Name of Person Who Signed Authorization* | | | | | | | | | | | | | | | | |  | *Date of Signature* | | | | | | |
| Be rescinded, effective | | | |  | | | | | | *(Date)* | | | | | | | | | | | | | | | | |
| I understand that any action taken on this authorization prior to the rescinded date is legal and binding. | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  | | |  | | | |  | |  | | | | | |
| *Signature of Parent, Client, Legal Guardian, Personal Representative* | | | | | | | | | | | |  | | | *Date* | | | |  | | *Relationship/Authority* | | | | | |
|  | | | | | | | | | | | |  | | |  | | | |  | |  | | | | | |
| *Signature of Witness* | | | | | | | | | | | |  | | | *Date* | | | |  | | *Relationship/Authority* | | | | | |