

# CHILD AND FAMILY CONNECTIONS CONSENT FOR RELEASE OF INFORMATION

Child's Last Name, First Name & Middle Initial \_\_\_\_\_  
 Child's Date of Birth (Month/Day/Year) \_\_\_\_\_  
 Cornerstone Participant ID # \_\_\_\_\_ CBO/EI # \_\_\_\_\_

**I authorize Child and Family Connections to release/obtain the below information:**  
 (check one) \_\_\_\_\_ **TO** \_\_\_\_\_ **FROM**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State & Zip \_\_\_\_\_

**Specific Information to be Disclosed if Available**

Obtain	Release	Type of Information	Description (timeframe, date of service)
		Developmental Reports	
		Occupational Therapy Reports	
		Physical Therapy Reports	
		Speech/Language Reports	
		Audiological Reports	
		Vision Reports	
		Medical Reports, Diagnosis, Prescriptions	
		Program Eligibility & Financial Status	
		Eligibility Information to Referral Source	
		Other	

**This information is needed for the following purpose(s):** (check all that apply)

- |   |   |
|---|---|
| _____ Establish Early Intervention eligibility      | _____ Coordinate, monitor and implement EI services |
| _____ Develop an Individualized Family Service Plan | _____ Facilitate transition                         |
| _____ Treatment, payment, healthcare operations     |   |

**This consent for disclosure is valid until:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Month Day Year

I understand that I have the right to inspect and copy the information to be disclosed. I understand that my consent is voluntary and that I may withdraw this consent by written request to the CFC above at any time, except to the extent that it has already been acted upon. I understand that my refusal to consent to disclosure will have the following consequences, if any:

Inability to establish EI eligibility; develop an IFSP; coordinate, monitor and implement services; or facilitate transition.

Other consequences: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Surrogate Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

**Notice to Receiving Agency/Person:**

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Family Educational Rights and Privacy Act, 20 USC 1232g, and the Health Insurance Portability and Accountability Act of 1996, information collected hereunder may not be redisclosed unless the person who consented to this disclosure specifically consents to such redisclosure or the redisclosure is allowed by law.

**Send Information to:** (enter name and address)