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 the Child and Family Connections (CFC) office to release/obtain the information below*:** ☐ **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 (EI) eligibility
☐ Develop an Individualized Family Service Plan (IFSP)
☐ Treatment, payment, healthcare operations
☐ Coordinate, monitor and implement EI services
☐ Facilitate transition
☐ Other: _____

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/Surrogate Printed Name: _____

Parent/Guardian/Surrogate Signature: _____ Date _____

Witness Signature: _____ Date _____

Notice to Receiving Agency/Person:	***Send Information to:*** (enter name and address)
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.	Name: Office Name: Address: City: State: Zip Code: