

## **Collaborative Authorization for Release of Information Rationale and Explanation for Use**

Families of children ages birth through age five years frequently access education and/or care services from multiple agencies/providers. These agencies/providers need to share information on these children for various reasons:

1. To facilitate the transition of children and families from one agency/provider to another.
2. To offer collaborative or blended services such as through the Universal Pre-K System or some other similar service arrangement.
3. To have available comprehensive information about the child to support planning appropriate services for the child and his or her family.

Use of a commonly adopted collaborative release of information form and appropriate training for personnel and families in its use by all agencies/providers in the same community:

1. Makes it easier for families to understand “the paperwork”, because the various agencies/providers with which the family is working are using the same release. This helps promote informed consent related to the release of records.
2. Allows agencies/providers to use one form with multiple agencies/providers if releasing or obtaining information for the same purposes, thus, reducing paperwork and duplication of efforts for families and the agencies/providers that serve them.
3. Ensures that the release meets the requirements of the involved agencies/providers.

It is essential to provide training to users of this form to ensure conformity with its stated intent. It is also important for staff to clarify to parents/guardians that this is not a “blanket” authorization; that they may select from among the records listed and are not compelled to check every record. Staff should explain the purpose of each record being authorized for release (i.e., the hearing evaluation would be necessary for planning for the child’s education services, etc.). Ideally, staff should enter this information on the form in the space provided for descriptions of each item prior to having the item initialed and dated by the parent/guardian.

The Collaborative Authorization for Release of Information has been approved by the:

1. WV Department of Health and Human Resources, Bureau for Public Health, Office of Maternal, Child, and Family Health, WV Birth to Three\*
2. WV Department of Health and Human Resources, Bureau for Children and Families, Division of Early Care and Education
3. WV Department of Education
4. Region III Administration for Children and Families, Health and Human Services, Head Start and Early Head Start

\*Note: WV Birth to Three also has an “Authorization to Obtain Medical Information” form that is available at [www.wvdhhr.org/birth23](http://www.wvdhhr.org/birth23).

## Collaborative Authorization for Release of Information

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Parent/Guardian's Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 Child's Physical Address if Different from Mailing Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Child's Current Provider/Program: \_\_\_\_\_

I hereby authorize the following information to be released or obtained:

Check all records to which this release applies and briefly describe if appropriate. Have the parent/guardian initial and date each record to which this release applies.		
Information To Be Shared/Description	To Be Released	To Be Obtained
Screening Information		
Developmental/Assessment Reports		
Psychological Report		
Educational Report		
Social History		
Individualized Family Service Plan		
Individualized Education Plan		
Speech/Language Report		
Health/Medical Report		
Physical Therapy Report		
Occupational Therapy Report		
Hearing Evaluation		
Vision Evaluation		
Other		
Other		

I only authorize the use or disclosure of information for the following specific purpose:

Release to:	Obtain From:
Individual Name: _____ Agency Name: _____ Address: _____ Phone: _____ Fax: _____	Individual Name: _____ Agency Name: _____ Address: _____ Phone: _____ Fax: _____

This authorization is valid from \_\_\_\_\_ until \_\_\_\_\_ (specify the date, event, or condition upon which this release of information expires) or until the child exits the program.

I understand these records are protected by state and federal law, including the Family Educational Rights and Privacy Act (FERPA), the Individuals with Disabilities Education Act (IDEA) and the Health Insurance Portability and Accountability Act (HIPAA). These records cannot be disclosed, given, sold or transferred in any way to any other person not specified in this release. I understand that I may withdraw this consent for release at any time prior to its expiration by providing written notice of revocation to the person and/or entity identified above. This written revocation will take priority over this authorization, except to the extent that the person or entity has already relied on this authorization prior to receipt of my written revocation.

\_\_\_\_\_  
Signature Relationship Date

\_\_\_\_\_  
Witness Date

**REDISCLASURE PROHIBITED:** This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law that prohibits you from making any further disclosures of it without the specific written consent of the person to whom it pertains, their parents/guardians or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.