Skagit Multidisciplinary Autism Review Team (SMART)
Authorization for Disclosure of Health, Developmental, Social, and Educational Information

Child/Youth Name ______________________________ Date of Birth ____________________

I authorize the exchange of Health, Developmental, Social, and/or Educational Information between SPARC/SMART, Skagit County Public Health, Peace Health Medical Group, and the following parties[i]:

☐Primary Care Provider		☐Early Intervention Provider	
Name/ Contact Info:		Name/ Contact Info:	
☐Speech/Language Therapist		☐School District	
Name/ Contact Info:		Name/ Contact Info:	
☐Occupational Therapist		☐Other	
Name/ Contact Info:		Name/ Contact Info:	
☐Physical Therapist		☐Other	
Name/ Contact Info:		Name/ Contact Info:	

Information to be disclosed:

☐ All health, developmental, social and educational information

☐ The following specific information only: ____

Authorization to Disclose:

We need your consent to release your health information to someone else. In addition, we need special consent to release your information about mental health, drug or alcohol use, HIV/AIDS, or sexually transmitted diseases.

NONE of the information below can be released without your initials. When you write your initials next to an item, you are giving permission for this information to be released.

_____ Sexually Transmitted Diseases _______ Drug and Alcohol _______ HIV/AIDS _______ Mental Health

Purpose of disclosure: Care coordination and developmental evaluation and/or services

Expiration of authorization: This authorization is effective for one year from the signature date below.

Right to cancel: You can cancel this authorization by writing to SPARC. Call 360-416-7570 for details.

You may refuse to sign this authorization. You can still receive information from SPARC/SMART if you do not sign.

I authorize disclosure: ☐ Client ☐ Parent/Guardian ☐ Personal Representative (specify authority)________

I acknowledge that I have received a copy of *HIPAA Notice of Privacy Practices from* ☐ *SPARC and* ☐ *Skagit County Public Health.*

Signature ______________________________ Date ______________ Phone # ________________

Re-disclosure is prohibited: We cannot guarantee that the recipient of this information will not give it to someone else. However, state and federal laws say information in your health and educational records must stay confidential. Your written permission is required for disclosure except as otherwise permitted by law.

1/13/2016

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Emily Molina, Community Health Worker

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