**PURPOSE:** As a parent/ guardian, you have the right to give or not give permission for the release of your child’s records to other persons or agencies. By signing this authorization you are giving permission to exchange confidential information for Autism Spectrum Disorder screening purposes.

**CHILDS NAME:** **DOB:**

I hereby authorize the exchange of information orally, in writing, or electronically between the **School Medical Autism Review Team** (SMART) and the agencies/persons listed below:

|  |
| --- |
| Northwest Pediatric Center  1911 Cooks Hill Rd Centralia, WA 98531  Phone: 360-736-6778 fax: 360-736-6552 |
| Primary Care Provider (if other than Northwest Pediatric Center): |
| Early Intervention Provider: |
| Daycare: |
| Therapist: |
| School District: |
| Other: |
| Other: |

**The records to be exchanged include:**

Medical/Health History information

Evaluation/Assessment results

Developmental information

Educational Reports (Progress/IEP/504/IFSP)

**This authorization is valid from ­­­­ to\_\_\_\_\_\_\_\_ \_\_. If not specified this authorization is valid for one year from date signed.**

I understand that the information obtained will be treated in a confidential manner and I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent release.

Parent/ Guardian Signature Date

Patient Signature (if patient is 13 years of age or older) Date