# C:\Users\rrayos\Desktop\Logo.pngSchool Medical Autism Review Team (SMART) Authorization for Release of Records

**Purpose:** As parent/guardian, you have the right to give or not to 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.

**Child’s 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:

|  |
| --- |
| Primary Care Provider:  |
| Early Intervention Provider:  |
| Daycare: |
| Therapist: |
| School District: |
| Other: |
| 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 prior consent release.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_/\_\_/\_\_\_\_

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