San Juan County Autism Collaborative Authorization for Release of Records

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 **San Juan County Autism Collaborative** and the agencies/persons listed below:

San Juan County Autism Collaborative PO Box 607 Friday Harbor, WA 98250 Fax: 360-378-7036
Primary Care Provider:
Early Intervention Provider:
Preschool/ childcare:
Therapist:
School District:
Other:
Other:

The records to be exchanged include:

- Medical/Health History information
- Mental Health History
- 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