The Department of Early Learning
Washington Early Support for Infants and Toddlers (ESIT) Program

Authorization for Release of Records

PURPOSE: As a parent, you have the right to give permission or not give permission for the release of your child's records to other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules in Part C of the Individuals with Disabilities Education Act (IDEA) and the Family Education Rights and Privacy Act, FERPA.

CHILD'S NAME _____ **DATE** _____

CHILD'S DOB _____ **LOCAL LEAD AGENCY** _____

I HEREBY AUTHORIZE THE EXCHANGE OF INFORMATION ORALLY, IN WRITING OR ELECTRONICALLY BETWEEN THE ESIT PROGRAM AND THE AGENCIES/PERSONS LISTED BELOW FOR THE FOLLOWING PURPOSE(S)
(check one or more):

- ❑ Determining eligibility for the ESIT program
- ❑ Identifying appropriate early intervention services through the IFSP process
- ❑ Sharing evaluation/assessment results and all progress notes
- ❑ Other (specify) _____

_____ and _____
Name of agency/person *Name of agency/person*

_____ _____
Street Address *Street Address*

_____ _____
City, State, Zip *City, State, Zip*

and _____
Name of agency/person

_____
Street Address

_____
City, State, Zip

and _____
Name of agency/person

_____
Street Address

_____
City, State, Zip

and _____
Name of agency/person

_____
Street Address

_____
City, State, Zip

THE RECORDS TO BE EXCHANGED INCLUDE (check all that apply):

- ❑ Medical/Health information
- ❑ Evaluation/assessment results
- ❑ Mental health information
- ❑ Current developmental information
- ❑ IFSPs/Progress notes
- ❑ Other (specify)

I understand that this information obtained will be treated in a confidential manner by the local lead agency under the provisions of Part C of IDEA and FERPA. IDEA and FERPA prohibit disclosure of personally identifiable information without consent except in limited circumstances.

NOTE WHICH TIME FRAME APPLIES:

❑ This authorization is valid for one year. Specify end date: _____
End Date

❑ This authorization is valid from: _____ to _____
Date *Date*

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 for release.

_____ _____
Parent Signature *Date*