CITY OF SEATTLE - ECEAP-STEP AHEAD-HEADSTART

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

AUTHORIZATION TO DISCLOSE RECORDS OF:

NAME LAST	FIRST	MIDDLE	DATE OF BIRTH

Medicaid ID # or other information:	PARENT/GUARDIAN NAMES

DISCLOSE TO: **(Completed by Program Staff)**

SITE/PROGRAM NAME

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS

REASON FOR DISCLOSURE

ECEAP/STEP AHEAD/EARLY HEAD START/HEAD START/ REGULATIONS

AUTHORIZATION

SOURCES: I authorize the mutual exchange of information about my child as described below. Information may be provided verbally or by computer data transfer, mail, fax, or hand delivery. (CIRCLE ALL THAT APPLY)

Provider:

ADDRESS:	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)

RECORDS: I authorize the following records be disclosed:

- ❒ EPSDT EXAM/TREATMENT
- ❒ DENTAL EXAM/TREATMENT
- ❒ HEALTH (DATED FROM _____ TO _____)
- ❒ DEVELOPMENTAL SCREENING
- ❒ IMMUNIZATION
- ❒ OTHER: _____

This authorization is valid for 90 days unless otherwise specified: _____.

I may revoke or withdraw my permission in writing at any time, but that will not affect information already disclosed.

- I understand that these records will be treated as confidential by the Head Start/Early Head Start/ECEAP/Step Ahead program.
- A copy of this form is valid to give permission to disclose records.
- Information disclosed through this authorization may be shared and is no longer protected by HIPAA.
- Authorizing the disclosure of this information is voluntary. I do not need to sign this form in order to assure treatment or payment.

PLEASE NOTE: **If confidential records include any of the following information, you must also complete the below section to allow disclosure of these records**.

SPECIAL RECORDS: I give my permission to disclose the following records (check all that apply):

- ❒ HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.24.105)
- ❒ Mental health records (RCW 71.05.620) including:_____
- ❒ Chemical Dependency (CD) records (42 CFR Part 2) including:_____

Notice to those receiving information: If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.

AUTHORIZATION BY (SIGNATURE)	RELATIONSHIP TO CHILD	DATE SIGNED	TELEPHONE # (INCLUDE AREA CODE)

PRINT NAME	INTERPRETER (SIGN AND PRINT NAME, IF APPLICABLE)

If I am not the person who is the subject of the records, I am authorized to sign because I am the:

❒ Parent of minor ❒ Legal Guardian ❒ Other:_____

(See reverse side for instructions)

INSTRUCTIONS FOR COMPLETING
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Staff need to ensure that all areas are completed. Use N/A for sections that do not apply.

- **Authorization to Disclose Records** – Completed by staff or parent.
  Reason for disclosure is pre-printed on the form.

- **Disclose to** – Completed by ECEAP staff.
  Be sure to include the Medicaid identification number found on the medical coupon.

*If multiple providers are to be contacted, form may be photocopied at this point.

- **Authorization** – Completed by staff or parent. Separate form required for each provider.
  Check all records that apply.

- **Special records** – Complete only as needed.
  Note special disclosure conditions for this information.

- **Authorization/Signature** – Must be original on all forms.