

# Authorization to Release Information

<b>Child's Name:</b>	<b>Date of Birth:</b>
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I authorize the Early Learning Coalition of Manatee County, Inc. and the following checked agencies and programs to obtain and exchange information:

- |   |  |
|---|--|
| <input type="checkbox"/> Child Find/FDLRS                                     | <input type="checkbox"/> Children's Medical Services               |
| <input type="checkbox"/> Early Steps/Sarasota Memorial Hospital               | <input type="checkbox"/> Children's Therapy Solutions/Manatee Hope |
| <input type="checkbox"/> Manatee Glens  | <input type="checkbox"/> Children's Therapy Associates             |
| <input type="checkbox"/> Whole Child Project Manatee                          | <input type="checkbox"/> Children's Therapy Works                  |
| <input type="checkbox"/> Department of Children and Families                  | <input type="checkbox"/> Child Care Provider                       |
| <input type="checkbox"/> Safe Children's Coalition                            | <input type="checkbox"/> Guardian Ad Litem: _____                  |
| <input type="checkbox"/> The Kidspot  | <input type="checkbox"/> Blake Medical Center                      |
| <input type="checkbox"/> Local, County, State, Federal, other funding sources | <input type="checkbox"/> Pediatrician: _____                       |
|   | <input type="checkbox"/> Other: _____                              |

I authorize the listed persons, agencies, and programs to engage in ongoing verbal and/or written communication for my child. All pertinent records and information can be released between agencies as necessary for the purpose of coordinating services for my child, including, but not limited to the exchange of developmental screening forms, medical records and any other pertinent information between Early Learning Coalition of Manatee County, Inc. and the stated funding sources, agencies or individuals for the purpose of evaluation, services and monitoring. I am aware this information will be strictly confidential and used only in my child's best interest.

I am also aware that I may deny consent for disclosure to any of the agencies and programs listed above.

I understand my rights in regard to this consent. Information shall be maintained in a confidential manner in accordance with the professional guidelines of the parties above. This release is valid for one (1) year from the date of signature.

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

