Unit/Area:_____

Date Sent to Provider:_____

RELEASE OF INFORMATION

I hereby authorize South Central Child Development, Inc. to release or obtain verbal or written information concerning:

_____	____/____/____	_____ - _____ - _____
(Child's Name)	(Birth Date)	(Social Security Number)

EDUCATION School District _____

Education Co-op _____

Head Start Program _____

Agency _____

WIC/Community Health Nurse _____

The following information can be released: **(Parents or Legal Guardians Initial)**

_____ Developmental Screening	_____ Hearing Screening
_____ Vision Screening	_____ Individual Education Plan (IEP)
_____ Individual Family Service Plan (IFSP)	_____ Professional Diagnosis
_____ Occupational Therapy Screening/Evaluation	_____ Psychological Evaluation
_____ Multidisciplinary Evaluation	_____ Professional Observation
_____ Written Invitation to all IEP Meetings & Reviews	_____ Physical Therapy Screening/Evaluation
_____ Speech Language Screening/Evaluation	_____ Progress Notes

MEDICAL **NAME:** **ADDRESS:** **PHONE & FAX #**

Clinic/Doctor: _____

Dental Office/Doctor: _____

WIC/Community Health Nurse: _____

The following information can be released:

_____ Physical Exam Results	_____ Hematocrit/Hemoglobin Results
_____ Blood Pressure Results	_____ Dental Exam Results/Treatment
_____ Immunization Records	_____ Vision Exam
_____ Lead Test Results	_____ Hearing Exam

Parental Consent: **"CONSENT"** means that the parent(s)/guardian(s) have been fully informed of all information relevant to the activity for which consent is sought, in the native language or other mode of communication: the parent(s)/guardian(s) understand and agree in writing to the carrying out of the activity for which consent is sought, and the consent describes the activity and lists any records which will be released or obtained and to whom, and the granting of consent by the parent(s)/guardian(s) is voluntary and may be revoked in writing at anytime.

THE PURPOSE OF THIS RELEASE HAS BEEN EXPLAINED.

_____ _____

Authorized Signature of Parent or Legal Guardian Date

NOTE: A **photocopy** of this release shall be as valid as the original. This release is valid until revoked by Parent/Guardian.

PLEASE SEND RECORDS TO: South Central Child Development, INC.
401 Walnut Street SW
Child File (white/original copy) **Wagner, SD 57380**
Area Manager (yellow copy) **Toll Free: 1-877-384-3683**
Parent/Guardian (pink copy) **Fax: (605) 384-5696**