Help Me Grow Home Visiting
Authorization to Release Information

I, _____, request that the following information about myself and / or my child(ren):_____ be shared (initial all that apply):
(Name)
(Name(s))

_____ Identifying information; including: family names, addresses and phone numbers
(initial)

_____ Child health and/or development screenings
(initial)

_____ Health diagnoses, treatment, care plans and/or prognosis; including:
(initial)

- **YES / NO**_____ mental health
  (initial)
- **YES / NO**_____ alcohol/drug use or treatment
  (initial)
- **YES / NO**_____ HIV/AIDS
  (initial)

_____ Other Information: _____
(initial)

This information will be shared between _____ and:_____
(Agency and/or Individual)

For the Purpose of case planning, coordination of services and to work cooperatively with other agencies on behalf of my family.

Child's DOB: _____

Date Release Begins ____/____/___

I understand that this release is good for one year and that I may cancel this release at any time. I understand that the cancellation will not affect any information that was already released before cancellation. I understand that information about me or my child(ren) is confidential and protected by state and federal law. I approve the release of this information. I am signing on my own and have not been pressured to do so.

Name (Print): _____Signature:_____

If <u>for any reason</u> you wish to discontinue the exchange if information between the parties listed above:

Date Release Withdrawn: ____/____/_____ Signature:_____