Allegan Area Educational Service Agency
310 Thomas Street
Allegan, MI 49010
269-512-7700

EARLY ON AUTHORIZATION TO SHARE HEALTH INFORMATION

Child's Full Name: _____ Birthdate: _____

Parent/Guardian: _____ Today's Date: _____

Parent/Guardian: _____ _____

Purpose

To Plan and provide the best care for your child and family, various professionals will need to share important health information. This information will be used to help decide if your child is eligible for Early On Services and to Coordinate these services with other agencies. This voluntary form authorizes these professionals to share information you would like shared.*

Information - Please list your child's primary health care provider.

Doctor Name/Office Name/Address/Phone	Specific Information to be Shared	Consent
Dr._____ Office_____ Address_____ City_____ Phone _____	Health/Medical Reports Developmental History/Evaluations	**Do you give consent for this information to be shared with the Allegan AESA?** ☐ **Yes** ☐ **No** **Parent Initial**:_____

Consent

My signature below means I understand that:

- My authorization to allow the sharing of information about my child is voluntary and expires upon exit from *Early On* or my child's third birthday.
- Information regarding behavioral and mental health services or communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Deficiency Syndrome or AIDS related complex) may be shared if I **INITIAL HERE** _____ or if I list this type of information above.
- Information received under this authorization becomes part of my child's educational record, is protected by the Family Educational Rights and Privacy Act (FERPA), and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPPA).
- Information may be re-disclosed by *Early On* as part of the educational record protected by FERPA.
- I may refuse to sign this authorization.
  - Refusal to sign may affect the ability of *Early On* to obtain information necessary to demonstrate that my child meets *Early On* eligibility criteria.
  - If my child is found eligible for *Early On*, refusal to sign this authorization will not affect my ability to obtain *Early On* services. However, the information obtained can help provide services that are individualized for my child.
- I may revoke or cancel consent at any time, without penalty, by notifying *Early On* in writing. Information that has already been shared based on this authorization cannot be taken back.

I have read and understand this authorization form (or had it read to me in a language that I understand) and (Choose one below)

☐ **I authorize** the above listed medical provider or designee to engage in verbal, written, and/or electronic communication in order to share specified records and information.

☐ **Do not authorize** any information to be shared at this time.

Parent/Guardian Signature: _____ **Date:** _____