AUTHORIZATION TO OBTAIN AND RELEASE CONFIDENTIAL INFORMATION

In order to provide a complete assessment of your child and track your subsidy authorization, it is beneficial to exchange pertinent information between _____ and the following: physicians, psychologist, hospitals, clinics, mental health agencies, Doctors office, Case worker, Speech therapist, physical therapist, and DSHS. Therefore, I hereby authorize the exchange of any pertinent records, educational, psychological, or medical records as checked below regarding the named client between the following with the understanding that this information will not be transmitted to be a third party without my consent. Note: All information received by _____ will be placed in the client's record and will be available for inspection and review in accordance with the requirements of the Family rights and privacy Act of 1974.

Clients name: _____ Age: _____ BD: _____ Sex: _____

Address: _____ Phone: _____

Teacher: _____

Family child Care Name — Name of Agency: _____

FCC Address — Address: _____

FCC City, State Zip — AND — City: _____ State: _____ Zip: _____

FCC Phone number

FCC Fax number

Please check the following:

_____ Request for Records

_____ Request of _____ records

_____ Telephone Exchange

_____ Release of _____

Signed: _____ Date: _____

Address: _____

_____