

**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: \_\_\_\_\_

\_\_\_\_\_