



Polk County Birth to 3 Early Intervention Program

Consent to Disclose Confidential Information

100 Plaza Suite 180 - Balsam Lake, WI 54810

Phone: 715-485-8585

AUTHORIZED AGENT/ORGANIZATION	REGARDING RECORDS OF:
Polk County Birth to Three Early Intervention Program Health Department 100 Polk County Plaza, Suite 180 Balsam Lake, WI 54810 Phone: (715) 485-8585 Fax: (715) 485-8501 Attention: Dawn Larson	Name: Address: Date of Birth:

I HEREBY AUTHORIZE THE POLK COUNTY BIRTH TO 3 PROGRAM TO VERBALLY EXCHANGE, DISCLOSE TO, AND/OR RECEIVE FROM: Parent initial next to information to be disclosed to and/or received from.

Birth to 3 will <u>give</u> the following information to the agency listed below: <input type="checkbox"/> Evaluations/Report <input type="checkbox"/> Develop <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech/Language <input type="checkbox"/> Plan of Care <input type="checkbox"/> Progress Notes <input type="checkbox"/> Develop <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech/Language <input type="checkbox"/> IFSP <input type="checkbox"/> Transition <input type="checkbox"/> IFSP <input type="checkbox"/> Evaluations/Reports <input type="checkbox"/> Progress Notes <input type="checkbox"/> _____ <input type="checkbox"/> Ongoing Progress <input type="checkbox"/> Other (specify) _____	Birth to 3 will <u>receive</u> the following information to the agency listed below: <input type="checkbox"/> Medical Reports/Physical Exams (including diagnosis/prognosis) <input type="checkbox"/> Developmental Reports/Records <input type="checkbox"/> Birth Records <input type="checkbox"/> Protective Service/Narratives/Reviews <input type="checkbox"/> Court Report/Custody Studies <input type="checkbox"/> Transition <input type="checkbox"/> IFSP <input type="checkbox"/> Evaluations/Reports <input type="checkbox"/> Progress Notes <input type="checkbox"/> _____ <input type="checkbox"/> Ongoing Progress <input type="checkbox"/> Other (specify) _____
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AGENCY WITH WHICH ABOVE ACTION(S) SHOULD BE TAKEN:

Name:
Address:

THE SPECIFIC PURPOSE OR NEED FOR SUCH DISCLOSURE IS:

<input type="checkbox"/> Obtain History	<input type="checkbox"/> Transition to other Program/Service
<input type="checkbox"/> Coordinate Care	<input type="checkbox"/> Other (specify)

Birth to 3 Consent: Parental consent is required before confidential information is shared with individuals outside the county administrative agency or service providers indicated on the IFSP or is used for any purpose other than the Birth to Three Program.

Birth to 3 Records: Early intervention records are confidential. Parents or their representatives have the right to inspect and review their entire child's early intervention records including those which relate to the identification, evaluation, assessment and the provision of early intervention services for their child. Parents will receive a summary of the county administrative agency record policy that includes information about the maintenance and disclosure of records.

<ul style="list-style-type: none"> I consent to the uses and disclosures of my protected information as described above. This authorization for disclosure of information has been fully explained to me and I understand it. I also understand that I may revoke this consent at any time. <u>This Consent To Disclose Confidential Information will expire one year from the date this consent form was signed.</u> 			
_____ Signature of Parent or Legal Guardian	_____ Date	_____ Signature of Witness	_____ Date

Health Department Consent: I understand I am required to consent to uses and disclosure of my protected health information for treatment, payment, and health care operations, in accordance with laws which protect my privacy and control the confidentiality of that information. This means that Polk County Health Department (PCHD) may:

- (1) use my protected health information to coordinate care within the Agency and with others involved in my care, such as my attending physician. The agency also may disclose my protected health care information to individuals outside the Agency involved in my care including family members, pharmacists, suppliers of medical equipment or other health care professionals.
- (2) Use my protected health information for billing, and disclose it to my health insurance company or government agencies that request information in connection with claims filed for care received from the agency.
- (3) Use and disclose my protected health information for activities that are considered health care operations. These operations include: Quality assessments and improvement activities; activities designed to improve health or reduce health care costs; professional review and performance evaluations; accreditation, certification, licensing or credentialing activities.

Privacy Notice: I understand that PCHD has prepared a Privacy Notice which provides a more complete description of how my protected health information is used and disclosed to others, and what uses and disclosures require further authorization from me.

- I understand that I will be provided with a copy of the Notice at the time of receiving this consent.
- I understand that I have the right to request that PCHD restrict how my protected health information is used or disclosed to carry out treatment, payment and health care operations. This is further described in the Privacy Notice.
- The agency is not required to agree to my requested restrictions, but if they do, the restriction is binding.
- I understand that I may revoke this consent in writing except to the extent that the agency has already taken actions in reliance on it, and that I may do so by providing written notice to the Birth to 3 Coordinator.