

CONSENT TO RELEASE INFORMATION

Utah Department of Health Division of Community and Family Health Services
Children with Special Health Care Needs Bureau
ABLE Program
44 Mario Capecchi Drive, P. O. Box 144640
Salt Lake City, UT 84114-4640

As Parent/Legal Guardian/Self (circle one), I request that records be released regarding the following child:

Name: _____ Date of Birth: _____
Current Address: _____ City: _____
State: _____ Zip: _____ Phone Number: _____

as indicated below:

I consent to the release of information held by _____ to the Utah Department of Health, Children with Special Health Care Needs Bureau. Please send material to:

Children with Special Health Care Needs Bureau
44 Mario Capecchi Drive, P. O. Box 144640
Salt Lake City, UT 84114-4640

I consent to the release of information held by the Utah Department of Health, Children with Special Health Care Needs Bureau to: Name: _____

Organization: _____
Address: _____

This release is for the following type of information as checked below:

- | | | |
|--|---|---|
| Medical_____ | School_____ | Community_____ |
| <input type="checkbox"/> Immunization | <input type="checkbox"/> Achievement | <input type="checkbox"/> OT/PT |
| <input type="checkbox"/> Admit/Discharge Summary | <input type="checkbox"/> IQ/Psychological | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Newborn Screening Tests | <input type="checkbox"/> Attendance | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Feeding/Nutrition | <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Community Staffing |
| <input type="checkbox"/> Birth/Newborn Records | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Newborn Screening Tests |
| <input type="checkbox"/> Lab/Medical Imaging | <input type="checkbox"/> IEP/IFSP | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> Surgical Reports | | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Developmental | <input type="checkbox"/> Other Explain: | <input type="checkbox"/> Collaborative Consultation |

I understand that I may withdraw this consent to disclose information at any time by notifying you in writing. This consent remains **effective for one year** from the date last signed.

Signature: _____ Relationship to child: _____ Date: _____
Signature: _____ Relationship to child: _____ Date: _____
Signature: _____ Relationship to child: _____ Date: _____
Signature: _____ Relationship to child: _____ Date: _____
Signature: _____ Relationship to child: _____ Date: _____

For questions regarding this request, contact:

Name: Lila Hutchinson
Phone: 801-584-8552
Fax: 801-584-8562