

Ventura County Early Start Program

PARENT CONSENT

FOR ASSESSMENT/EVALUATION, RELEASE/EXCHANGE OF INFORMATION, REQUEST FOR SERVICE

Child's Name: _____	DOB: _____
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With your written consent, community agencies and the persons who represent them may share information with one another. Evaluation for the Early Start Program includes: finding out if your child is eligible for services, talking about what services are available, matching services to your child and family needs.

You need to know that:

- Your child may receive a developmental assessment.
- The information obtained is voluntary and will only be used to evaluate your child to determine his/her eligibility and need for services and provision of an Individual Family Service Plan.
- You may request copies of all records pertaining to your child.
- This consent for exchange is good for one year; you may withdraw your permission at any time by writing a note to your primary service coordinator. However, revocation of your permission will not apply to records already released.
- A photocopy of this document is as valid as the original.
- Sharing information helps agencies coordinate services for your child. You may choose which agencies shall exchange information.
- Information about your child and family is strictly confidential and will only be released to agencies and/or persons whom you choose in writing.
- You may refuse to sign this exchange form.
- You must be informed of the contents of this document in language you clearly understand.
- Information to be exchanged includes medical and health, developmental, speech and language, educational, hearing/vision and/or psychological.
- A copy of your parental rights which includes information regarding services which may be offered to the child and/or the family as part of the Early Start services, is attached.

I request coordination of Early Start services and agree to the exchange of information among the agencies checked below and the persons who represent them.

- | | |
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| <input type="checkbox"/> Tri-Counties Regional Center (TCRC) | <input type="checkbox"/> Family Resource Center |
| <input type="checkbox"/> Local Education Agency/Vendor | <input type="checkbox"/> Primary Care Physician, Clinic please specify |
| _____ | _____ |
| _____ | _____ |
| <input type="checkbox"/> County Health Department including Public Health Nursing and California Children's Services (CCS) | <input type="checkbox"/> Hospital _____ |
| | <input type="checkbox"/> Other _____ |

I understand that I may limit what information is exchanged. List any limitations: _____

I acknowledge that I have received a copy of the Parents' Rights & Responsibilities Regarding Evaluation and Assessment in the Early Start Program under IDEA.	
_____	_____
Parent/Guardian	Date
_____	_____
Parent/Guardian	Date