CONSENT TO RELEASE INFORMATION

Able-differently Program
PO Box 9757
Salt Lake City, Utah, 84109
801-520-7376

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 child's school/primary care doctor _____ to the following addresses:

Health care provider address c/o_____
Child's School address c/o_____
Other parity c/o_____

☐ **I consent to the release** of information held by Able-differently Program c/o
Name:_____(above address)_____

Organization:_____

Address:_____

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

Medical____	School____	Community____
☐ Immunization ☐ Medical	☐ Achievement	☐ OT/PT
☐ Admit/Discharge Summary	☐ IQ/Psychological	☐ Social Services
☐ Newborn Screening Tests	☐ Attendance	☐ Dental
☐ Feeding/Nutrition	☐ Speech/Language	☐ Community Staffing
☐ Birth/Newborn Records	☐ Behavioral	☐ Newborn Screening Tests
☐ Lab/Medical Imaging	☐ IEP/IFSP	☐ Hearing
☐ Surgical Reports		☐ Vision
☐ Developmental	☐ Other Explain:	☐ 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:_____

Signature:_____Relationship to child:_____Date:_____

For questions regarding this request, contact:

Name: Louis Allen

Phone: 801-520-7376