Medical Home–Early Intervention Information Referral/Release

This form will authorize the exchange of information between this child's Medical Home Provider and the Early Intervention Program

When completed, this form should be handed, mailed, or faxed to your local Early Intervention Program

Release of information

Child's First & Last Name:	Parent/Guardian's Name:	Address: Phone:
Early Intervention Program:	Address:	Phone Number: Fax:

I, the undersigned, authorize the release of information relating to the diagnosis/condition listed below regarding the above-named child to the early intervention program and appropriate early intervention providers AND authorize the early intervention program to release and discuss information and reports with the named physician and/or his/her assigned office personnel.

Parent/Guardian's Signature	Date:	If applicable, my consent expires:

Information or records not be released include:

Physician contact info

Medical Home Provider (MD, DO, PA, NP) Name:	Phone Number:	Fax Number:
Mailing Address:	Email Address:	

Preferred Method and Time for Contact:

Diagnosis/ Screening Information

Reason for Referral, Screening Results, and/or Concerns:

Most recent evaluation of the following:
Well Child Exam, date:_____; relevant findings:

Vision exam, date:_____; relevant findings:
Hearing exam, date:_____; relevant findings:

Medical Home Provider Signature:	Date:

To be completed by Early Intervention and returned to the Medical Home Provider

E.I. Follow up

Eligible: ❒ yes _____

_____

❒ no _____

_____

Eligibility Form Attached ❒ IFSP Attached❒