**AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION:**

**TRAINING AND QUALITY ASSURANCE**

I hereby authorize the use of photographs, written materials, and videos which may include the name of my child:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(print full name of child)

and family members (including myself):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(print full names of family members)

When I sign this Authorization, I will allow Children’s Medical Services and Early Steps to use and disclose my health information for the following purposes:

□ Consultation between members of my IFSP Team or Zone Team to inform intervention strategies,

□ Training and professional development of Early Steps staff and service providers,

□ Record keeping for Quality Assurance and Continuous Improvement Plans that are monitored by the

Early Steps State Office.

I understand that these photographs, written materials, and videos may be edited for training and consultation purposes, and that they will be stored as Protected Health Information with access restricted except to those entities described above.

I understand that these videos may not be used outside of Early Steps for training, educational, or promotional purposes, unless specifically authorized by me in a separate document.

I sign this authorization voluntarily, and understand that I may refuse with no impact to my services.

Signed:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

*Your Address:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street, City and Zip Code

***\*\*Authorization not valid or to be used for children in Foster Care System***

Children’s Medical Services: [www.cms-kids.com](http://www.cms-kids.com)

Health Planning Council of Southwest Florida: [www.hpcswf.com](http://www.hpcswf.com)