Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Department of Health and Human Services
Early Development Network
Authorization of Release/Request for Information

Early Development Network
Getting Families Connected

Initiating Agency	Contact Person
Agency Address	Phone Number
Child's Full Name	
Child's Social Security Number	Date of Birth

I give my consent, as the parent/guardian of the minor child, to the agencies identified below to share the information that I have initialed:

Initials	Type of Information
	Health Information, specify:
	Diagnostic/Therapy Reports, specify:
	Educational Records, specify:
	Early Intervention Record, specify:
	Other Information, specify:

Listed below are a number of agencies that provide services for children with special needs and their families. The purpose for this exchange of information is to help coordinate services, provide appropriate programs, and to make sure my child and family get services as quickly as possible. I am putting my initials next to the agencies that I want to share information identified above.

Initials	Agency/Program
	School District, specify:
	Hospital, specify:
	Nebraska Department of Health and Human Services
	Physician/Clinic, specify:
	Other, specify

I understand:

1) I have the right to withdraw my consent at any time;
2) Consent for release of information can be revoked by sending a signed request to my Early Development Network Services Coordinator at:

   _____

3) I have the right to inspect and copy the information to be shared;
4) Treatment, enrollment, or eligibility of benefits provided per the Nebraska Department of Health and Human Services are not conditioned by signing this release;
5) If I do not give my consent to share information, the agencies may not be able to determine the best services available for my child and family; and
6) Information used/disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and/or no longer protected if the recipient is not a health plan or health care provider.

I am providing my consent voluntarily, and I understand the information on this form.

Signature of Parent/Guardian	Relationship to Child	Date
Street Address	City/State/Zip Code	Phone Number

Unless otherwise stated, this release is valid for one year from_____ to_____.