



RELEASE OF INFORMATION

NAME OF CHILD	DATE OF BIRTH	DATE COMPLETED
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INSTRUCTIONS

Parent consent is required before a System Point of Entry (SPOE) can request or share a child or family's personally identifiable information with anyone outside of the First Steps program.

The Service Coordinator must explain each section of this form to the parent so the parent can decide the specific information to request from or share with the individual/agency named below. Based on the parent's decision, the Service Coordinator checks the appropriate boxes.

The parent must sign and date the form and return it to the Service Coordinator before child or family information can be requested or shared. The Service Coordinator contact information is included below.

PURPOSE

The First Steps SPOE _____ may contact the following individual/agency:

INDIVIDUAL/AGENCY NAME	ADDRESS/PHONE NUMBER
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Information about my child and family may be: (check one)

- Shared between the First Steps SPOE and the outside individual/agency
- Requested from the outside individual/agency
- Released from the First Steps SPOE to the outside individual/agency

The purpose of this contact is to assist with:

- Eligibility determination for First Steps
- Development of an Individualized Family Service Plan (IFSP)
- The child's services and progress
- Transition to Early Childhood Special Education (ECSE)
- Other: _____

TYPE OF INFORMATION

The type of information to be requested or shared:

- The child's entire early intervention record

Or indicate the specific records below:

- Health and medical records. Specify: _____
- IFSP
- Evaluation and assessment reports. Specify: _____
- Provider progress notes
- Documentation of ECSE eligibility
- Directory Information if First Steps eligibility is unknown
- Date referred to First Steps (_____) is 90 days before third birthday? Yes No
- Other: _____

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, national origin, age, or disability in its programs and activities. Inquiries related to Department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Office of the General Counsel, Coordinator – Civil Rights Compliance (Title VI/Title IX/504/ADA/Age Act), 6th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email civilrights@dese.mo.gov.

NAME OF CHILD	DATE OF BIRTH
CONDITIONS OF CONSENT	
<p>I understand that, by signing this form:</p> <ul style="list-style-type: none"> • I have the right to inspect and copy the information shared or received. • Information received from an individual/agency becomes part of the child's early intervention record. • Any records sent to First Steps will be subject to re-disclosure by First Steps as permitted by the Family Educational Rights and Privacy Act (FERPA). • If I do not give my consent to request medical information, the First Steps SPOE will determine eligibility and/or services based on the available information. • If my child is eligible to participate in the First Steps program, I will still be enrolled and receive services even if I do not sign the release. • The information released may include information relating to genetic testing, mental health services, acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or treatment for drug abuse. • I have a right to take back this release at any time. I understand that if I take back this release, I must do so in writing and present my written statement to take back this release to the Service Coordinator. I further understand that actions already taken based on this release, prior to taking back this release, will not be affected. 	
This release of information will remain in effect until my child is no longer receiving First Steps services unless I specify an expiration date.	EXPIRATION DATE
CONSENT	
I understand, by signing this form, I am providing my consent voluntarily to request or share the information specified on this form.	
PARENT SIGNATURE	DATE OF PARENT SIGNATURE
PRINTED NAME OF PARENT	
SERVICE COORDINATOR	
SERVICE COORDINATOR NAME	SERVICE COORDINATOR PHONE NUMBER
AGENCY NAME AND ADDRESS	AGENCY FAX NUMBER
FOR SPOE USE ONLY	
SIGNATURE OF AGENCY REPRESENTATIVE	DATE RECEIVED BY AGENCY