300 S. Capitol, P.O. Box 231
Mount Sterling, Illinois 62353
Phone: 217-773-3903
FAX: 217-773-3906

Disabilities/Mental Health Services Authorization for Release of Information

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(CFC, EC, School, Therapists, Co-op, etc. clinic, medical provider, hospital, **and address**)

is hereby authorized

to release to PACT all relevant information and records for the purpose of planning and coordinating services for my child:

______________________________ ______________________________
Name of Child | Birth Date

______________________________ ______________________________
Street Address/ Rural Route /CR/Box # | City, State and Zip Code)

Specific information requested:

- ❑ **Copy of IFSP/IEP**
- ❑ Eligibility Determination Report (If available)
- ❑ Complete Case Study (If available)
- ❑ Social Development Study (If available)
- ❑ Audiological Report (If available)
- ❑ Vision & Hearing Results (If available)
- ❑ Speech & Language Reports (If available)
- ❑ Psychological Reports (If available)
- ❑ Reports of recent testing and/or diagnosis, and doctor's or provider's impressions and recommendations.
- ❑ Other____

■ I give permission for PACT to release information for the purpose stated above during the period of services for my child.
■ I understand that this release will allow for two way conversation between the provider(s) and PACT personnel concerning my child's education planning and goal setting, etc.
■ This release is in effect for 1 year from the date signed unless revoked in writing by the undersigned. However, revoking this release will not have effect on actions taken by providers to whom the release was sent before revocation.
■ I understand that the information used or disclosed can be subject to re-disclosure by the agency receiving it and is not protected by the federal privacy regulations. However, PACT does not re-disclose information unless a written authorization is requested and signed by the parent(s).
■ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my child's services or my eligibility for benefits from the provider (listed above) or from them releasing info.

Signature: ____ Date: ________________
Parent or Guardian Name (If for a foster child, this must be signed by a DCFS Guardian)

HS Staff: Mail completed release to Disabilities/Mental Health Services Coord. at Central Office. Do not send to provider.