Capital Area Head Start 3705 Elmwood Dr, Harrisburg, PA 17110
(717)541-1795; Fax (717)541-8226
Pennsylvania Child/Adolescent
FERPA AUTHORIZATION/REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION
EXCHANGE OF INFORMATION (BOTH TO AND FROM) EXTERNAL AGENCY, KEYSTONE SERVICE SYSTEMS

For Office Use Only:
Child's Name________________________ Date of Birth ____________________ Child's SS#________________________

Parent's Name________________________ Center________________________ Classroom:________ Staff:________________

I do hereby authorize the person and/or agency indicated to exchange such confidential information and records as specified below with Keystone Service Systems, Inc. You are hereby released from all legal liability that may arise from such release.

EXTERNAL AGENCY: Agency: ____

Address: ____

Phone: ____

( ) Discharge Summary	( ) Medications	( ) Referral Form
( )Educational Information/ Developmental including ER/IEP/IFSP	( ) Dental Exam/Recommendations	( ) Treatment/Behavior Plan & Recommendations
( ) Family History	( ) Screenings: Lead/Hearing/Vision/Anemia	( ) Vocational information
( ) Financial information	( ) Progress Notes	( ) Asthma Care Plan
( ) Immunization information	( ) Psychiatric Evaluation & Diagnosis	( ) Allergy Care Plan
( ) Medical Examination/Recommendations	( ) Psychological/Social History	( )Other________________

Reason for release of information: ____

I/we understand that this disclosure will include (check if applicable):
[ ] Information relating to AIDS or HIV infection
[ ] Treatment for substance and/or alcohol abuse or dependency
[ ] Psychotherapy Notes
[ ] Other information relating to mental health or psychiatric care

This information is being disclosed to the above person, organization or agency from records whose confidentiality may be protected by the Pennsylvania Drug and Alcohol Abuse Control Act, the Pennsylvania Mental Health Procedures Act, and/or the Pennsylvania Confidentiality of HIV Related Information Act and Family Education and Right to Privacy Act. My signature below authorizes the release of information protected by these Pennsylvania and Federal statutes.

I/we understand that I have no obligation whatsoever to disclose information from my record. I/we also understand that Keystone Service Systems, Inc. cannot withhold treatment/services from me based upon my failure to execute this authorization, subject to the following: If the only purpose for this authorization is to allow a health care provider to perform tests (such as drug tests) or other health care services and then transfer the results of such tests or services to another party, the provider conducting such tests or other services may decline to perform such tests or services if I refuse to sign this authorization.

I/we understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I/we also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I/we fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. Keystone Service Systems, Inc, its employees, officers and clinical staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Finally, I/we understand that I/we am/are entitled to obtain a copy of this authorization from the Keystone Service Systems, Inc. upon request.

This authorization shall be effective immediately and will expire on______________________________not to exceed 365 days).

______________________________ ______________________________
Signature of Individual/Parent/Guardian* / Date Witness / Date
I have the legal authority on my own to make health related treatment decisions for my minor child.
Relationship if other than individual signing

I understand I have the right to a copy of this authorization. ( ) I accept a copy ( ) I decline a copy

<u>Revocation of Consent to release/exchange of information</u> ***DO NOT COMPLETE AT ENROLLMENT***
I hereby revoke my consent to release/exchange information between the two parties named above.

____
Signature of Individual/Parent/Guardian* Date
I have the legal authority on my own to make health related treatment decisions for my minor child.

Data Entered________________ Date Sent________________ Date Received________________
White: Office File Yellow: Teachers File Pink: Parent Copy