



**Early Childhood Cluster
Release of Information**

As the parent/legal guardian of the below named child

_____. DOB _____

I authorize the following agencies the right to exchange information regarding psychological and education assessments, treatment and progress updates. The purpose of this release it to plan for and access services to meet the needs of this child and/or family. Information released under this authorization may be subject to re-disclosure by the recipient of the information.

- Fairfield Department of Health
- Fairfield County Department of Job and Family Services (Community Services, Child Protective Services, Child Support, Visitation Center, Adult Services, Workforce Development)
- Fairfield County Board of Mental Retardation and Developmental Disabilities
- Department of Youth Services
- New Horizons Youth and Family Center
- The Recovery Center
- Fairfield County Help Me Grow
- Fairfield County ADAMH Board
- Fairfield County Schools
- Fairfield County Juvenile Court
- Fairfield Medical Center
- Big Brothers/Big Sisters
- Lighthouse Shelter
- Lancaster/Fairfield County Early Head Start and Head Start Programs
- Lancaster City Schools
- BCMh (Bureau of Children with Medical Handicaps)
- Mid-Ohio Psychological Services
- Fairfield County Family, Adult and Children First Council
- OSU-Family Research Project E-Score Project
- Other (Please List) _____

Release Expiration Date (up to one year) _____

Signature of Parent/Legal Guardian Date

Witness(Credentials) Date

Revocation of consent: I hereby revoke the above consent for release of information. Upon revocations of consent, further release of specified information shall cease immediately.

Signature of Parent or Guardian Date

Witness (Credentials) Date

Approved as to form Date