

## Authorization for Release and Disclosure of Developmental Screening Results

Parent/Personal Representative Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**I authorize, [Practice/Agency Name]** to share my Child's Developmental Screening results with the Vermont Department of Health to be included in the statewide Universal Developmental Screening Registry. The Developmental Screening Registry is an online database designed to allow primary care providers and community providers to enter developmental and behavioral screening data and share information.

### **Purpose for the Requested Use of Disclosure:**

Early identification of developmental concerns is critical to the well-being of children and their families. It is the responsibility of health care professionals and community providers to identify young children with developmental concerns as soon as possible so that children and their families can get the services and support they need. Screening results from any of the four (4) screening tools listed below may be included in the Registry:

- Ages and Stages Questionnaires: Third Edition (ASQ-3)
- Ages and Stages Questionnaire: Social Emotional Second Edition (ASQ:SE-2)
- Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R)
- Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-Chat-R/F)

**Statement of Understanding.** I understand and agree with the following statements:

- I understand why I am being asked to release my child's developmental screening results.
- I do not have to consent to the release of this information.
- Signing this authorization is voluntary.
- I may revoke this authorization at any time but I understand that the revocation does not apply to any action that has taken place prior to the date I revoked this authorization.
- To revoke this authorization, I must make this request in writing and send to: [Provider Address].
- If I do not revoke this authorization, it will expire in five (5) years from the date signed.
- I will be provided with a copy of this form.

All items on this form have been completed and my questions about this form have been answered. A photocopy of this Signed Release shall be as effective as the Signed Original.

Parent/Personal Representative Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_