## Developmental Pathways Consent Form for Mutual Exchange of Information 325 Inverness Drive South Englewood, Co 80112

lunderstand that Early Intervention Colorado is an interagency collaboration and that information about my child and family will be shared between the partners initialed below and Developmental Pathways (Community Centered Board) for support planning and development. This is in accordance the partners initialed below and Developmental Pathways (Community Centered Board), Public Health and Environment, Human Services, and Handling Colorado Parent    I hereby authorize the mutual exchange of information regarding the above named person between Developmental Pathways and the individuals or agencies listed below:    The County Health Department	Child's Name	Date of Birth
Pathways and the individuals or agencies listed below:  Tri- County Health Department Developmental Pathways Littleton Public Schools Cherry Creek Public Schools Sheridan Public Schools Sheridan Public Schools Seast Central BOCES Douglas Public Schools Arapahoe County Dept. of Human Services The Children's Hospital Littleton Advants Hospital Littleton Advants Hospital Swedish Medical Center Syeveish Medical Center Syeveish Medical Center Syeveish Medical Center Anchor Center St. Joseph Hospital Littleton Advants Hospital St. Anthony Hospital Littleton Advants Hospital Littleton Adv	the partners initialed below and Developmental Pathways with the 1995 Memorandum of Understanding among the Gentlement Health Care Policy and Financing.	(Community Centered Board) for support planning and development. This is in accordance
		Doctor(s)
	Tri- County Health Department	• •
Littleton Public Schools Englewood Public Schools Englewood Public Schools Aurora Mental Hourora Medical Center St. Joseph Hospital Swedish Medical Center St. Authory Hospital Aurora Mental Health St. Authory Hospital Aurora Mental Health St. Authory Hospital Aurora Mental Health Specifically, is there any person or agency that you do not give consent to review your child's information?  I hereby authorize the mutual exchange of information regarding the above named person between Developmental Pathways and school district Child Find for Three-year-Old school age (Part B) planning. Initials of Parent  I have been fully informed of the intended use of this information. I also understand that the agency/person receiving this information is obligated to maintain it in a confidential manner and that it is to be used only for the purpose I have authorized. I understand that this information will be kept in a database that is password protected, and for the exclusive use of the Part C service coordinators and their supervisors for the purpose of optimizing communication, resources, and supports for my child and family. I understand my consent is effective one year from the date of signing. I also understand that I may cancel all or any part by notifying Developmental Pathways at any time.  Signature of Parent Consenting  Witness  Date  HIPAA ACKNOWLEDGEMENT  I have received from Developmental Pathways, Inc. information on their compliance with the Health Insurance Portability and	Developmental Pathways	
Cherry Creek Public Schools Englewood Public Schools Sheridan Public Schools Aurora Public Schools East Central BOCES Douglas Public Schools Arapabee County Dept. of Human Services Arapabee County Dept. of Human Services Arapabee County Dept. of Human Services Douglas County Dept. of Human Services Arapabee County Dept. of Human Services By SkyRidge Hospital The Children's Hospital Author Center St. Joseph Hospital Author Center St. Joseph Hospital Author Center Author Center Author Center St. Anthony Hospital Author Center Author Center Author Center St. Anthony Hospital Author Center Author Center Author Center Author Center St. Anthony Hospital Author Mental Health Author Center Author Center Author Center Author Center Author Center Author Center St. Anthony Hospital Author Center of Aurora Author Center Author	Littleton Public School	Therapist(s)
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East Central BOCES Douglas Public Schools Arapahoe County Dept. of Human Services Douglas County Dept. of Human Services The Children's Hospital Swedish Medical Center St. Joseph Hospital Home Care Management St. Anchor Center Porter Hospital St. Anchor Hospital St. Anchor Hospital Home Care Management St. Anchor Hospital Aurora Mental Health St. Anthory Hospital University of Colorado Hospital Denver Health Specifically, is there any person or agency that you do not give consent to review your child's information?  I hereby authorize the mutual exchange of information regarding the above named person between Developmental Pathways and school district Child Find for Three-year-Old school age (Part B) planning. Initials of Parent I have been fully informed of the intended use of this information. I also understand that the agency/person receiving this information is obligated to maintain it in a confidential manner and that it is to be used only for the purpose I have authorized. I understand that this information will be kept in a database that is password protected, and for the exclusive use of the Part C service coordinators and their supervisors for the purpose of optimizing communication, resources, and supports for my child and family. I understand my consent is effective for one year from the date of signing. I also understand that I may cancel all or any part by notifying Developmental Pathways at any time.  Bate  Date  HIPAA ACKNOWLEDGEMENT  I have received from Developmental Pathways, Inc. information on their compliance with the Health Insurance Portability and	Sheridan Public Schools	Other (Specify)
	Aurora Public Schools	<del></del>
Araphoe County Dept. of Human ServicesDouglas County Dept. of Human ServicesThe Children's Hospital	East Central BUCES	
	Douglas Public Schools	
	Douglas County Dept. of Human Services	SkyPidge Hospital
Swedish Medical Center St. Joseph Hospital Porter Hospital Anchor Center Anchor Medical Center of Aurora University of Colorado Hospital University of Colorado Hospital Presbyterian/St. Luke's Hospital Lutheran Medical Center Lutheran Medical Center Lutheran Medical Center Specifically, is there any person or agency that you do not give consent to review your child's information?  I hereby authorize the mutual exchange of information regarding the above named person between Developmental Pathways and school district Child Find for Three-year-Old school age (Part B) planning.  I have been fully informed of the intended use of this information. I also understand that the agency/person receiving this information is obligated to maintain it in a confidential manner and that it is to be used only for the purpose I have authorized. I understand that this information will be kept in a database that is password protected, and for the exclusive use of the Part C service coordinators and their supervisors for the purpose of optimizing communication, resources, and supports for my child and family. I understand my consent is effective for one year from the date of signing. I also understand that I may cancel all or any part by notifying Developmental Pathways at any time.  Signature of Parent Consenting Witness  Date  Date  HIPAA ACKNOWLEDGEMENT  I have received from Developmental Pathways, Inc. information on their compliance with the Health Insurance Portability and	The Children's Hospital	
St. Joseph Hospital — Anchor Center — Aurora Mental Health — The Medical Center of Aurora — Aurora Mental Health — The Medical Center of Aurora — Rose Medical Center — Presbyterian/St. Luke's Hospital — Lutheran Medical Center — Denver Health — Denver He	Swedish Medical Center	
St. Anthony Hospital	Porter Hospital	
	St. Anthony Hospital	The Medical Center of Aurora
Social Security Administration Denver Health  Specifically, is there any person or agency that you do not give consent to review your child's information?    I hereby authorize the mutual exchange of information regarding the above named person between Developmental Pathways and school district Child Find for Three-year-Old school age (Part B) planning. Initials of Parent    I have been fully informed of the intended use of this information. I also understand that the agency/person receiving this information is obligated to maintain it in a confidential manner and that it is to be used only for the purpose I have authorized. I understand that this information will be kept in a database that is password protected, and for the exclusive use of the Part C service coordinators and their supervisors for the purpose of optimizing communication, resources, and supports for my child and family. I understand my consent is effective for one year from the date of signing. I also understand that I may cancel all or any part by notifying Developmental Pathways at any time.  Signature of Parent Consenting	University of Colorado Hospital	Rose Medical Center
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	HIPAA ACKNOWLEDGEMENT	

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