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

Child's Name_____ Date of Birth_____

I understand 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 with the 1995 Memorandum of Understanding among the Colorado Department of Education, Public Health and Environment, Human Services, and Health Care Policy and Financing.
Initials of Parent _____

I hereby authorize the mutual exchange of information regarding the above named person between Developmental Pathways and the individuals or agencies listed below:

__ Tri- County Health Department
__ Developmental Pathways
__ Littleton Public School
__ Cherry Creek Public Schools
__ Englewood Public Schools
__ Sheridan Public Schools
__ Aurora Public Schools
__ 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
__ Porter Hospital
__ St. Anthony Hospital
__ University of Colorado Hospital
__ Presbyterian/St. Luke's Hospital
__ Social Security Administration

__ Doctor(s) _____
_____
_____
__ Therapist(s) _____
_____
_____
__ Other (Specify)
_____
_____
_____

__ SkyRidge Hospital
__ Littleton Adventist Hospital
__ Home Care Management
__ Anchor Center
__ Aurora Mental Health
__ The Medical Center of Aurora
__ Rose Medical Center
__ Lutheran Medical Center
__ 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 Witness

_____ _____
Date Date

HIPAA ACKNOWLEDGEMENT

I have received from Developmental Pathways, Inc. information on their compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and a copy of the "Notice of Privacy Practices."
Initials of Parent _____

The terms of this consent shall not exceed one year from date of signature.