DEVELOPMENTAL DISABILITIES SERVICES / FIRST CONNECTIONS

EVALUATION & INFORMATION AUTHORIZATION

CHILD'S NAME _____ **CHILD'S ID NUMBER**_____

PARENT/GUARDIAN _____ **SERVICE COORD**_____

CONSENT TO EVALUATE:

I understand that I have the right to notice and consent in my native language before any action is taken concerning my child; and I am authorizing Developmental Disabilities Services and the First Connections Program to complete the following evaluations for my child.

____Developmental Evaluation __Speech Therapy ___Physical Therapy ___Occupational Therapy

___Other_____

Parent/Guardian Initial _____Yes _____No _____Date

CONSENT TO OBTAIN/RELEASE INFORMATION:

I understand that I have the right to notice and consent in my native language before any personally identifiable information about my child is released or obtained. I understand that I can revoke this authorization at any time. I also understand that I may examine any and all records pertaining to my child at any time. I am authorizing Developmental Disabilities Services and the First Connections Program to ___x___obtain from / ___x___release information to:

Organization/Individual_____ _____
Address _____ _____
_____ _____

Information to be Obtained / Released: _contact information, EI records, evaluation report(s), Rx for evaluation_

Parent/Guardian Initial _____Yes _____No _____Date

FAMILY CHOICE OF PROVIDERS:

I have been provided a list of providers available to conduct the above identified evaluations and have chosen the following providers:

___ Developmental Evaluation Provider_____
___Speech Therapy Provider_____
___Physical Therapy Provider_____
___Occupational Therapy Provider_____
___Other_____ Provider_____
___Other_____ Provider_____
___Other_____ Provider_____

___Parent/Guardian Initial _____Date

_____ _____

Parent/Guardian Signature **Date**

(Form FC-D) (electronic signature version 3/2020)