



School Medical Autism Review Team (SMART) Authorization for Release of Records

PURPOSE: As a parent/ guardian, you have the right to give or not give permission for the release of your child's records to other persons or agencies. By signing this authorization you are giving permission to exchange confidential information for Autism Spectrum Disorder screening purposes.

CHILDS NAME: _____ **DOB:** _____

I hereby authorize the exchange of information orally, in writing, or electronically between the **School Medical Autism Review Team (SMART)** and the agencies/persons listed below:

Northwest Pediatric Center 1911 Cooks Hill Rd Centralia, WA 98531 Phone: 360-736-6778 fax: 360-736-6552
Primary Care Provider (if other than Northwest Pediatric Center):
Early Intervention Provider:
Daycare:
Therapist:
School District:
Other:
Other:

The records to be exchanged include:

Medical/Health History information
Evaluation/Assessment results
Developmental information
Educational Reports (Progress/IEP/504/IFSP)

This authorization is valid from _____ to _____. If not specified this authorization is valid for one year from date signed.

I understand that the information obtained will be treated in a confidential manner and I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent release.

Parent/ Guardian Signature

Date

Patient Signature (if patient is 13 years of age or older)

Date