Shiawassee County 989-725-2581 or
Toll Free 1-866-725-7792 Fax 989-725-1312

Great Start Interagency Request for Protected Information (Health)

Child Information

Child's Legal Name: DOB:

Parent's/Guardian's Name:

Purpose

The purpose of this request is to collect information necessary to determine your child's eligibility for *Great Start*, and to plan and provide services as determined through the multidisciplinary team process.

Medical Provider(s) Authorized to Share Information with *Great Start*

Info to Share (Code)	Initial	Agency/Person		Info to Share (Code)	Initial	Agency/Person
		Shiawassee County Health Department				Hospital (specify)
		Shiawassee Community Mental Health Authority				Other (specify)
		Physician (specify)				*Great Start* Database
		Physician (specify)				

Information Codes

1. Health/Medical Records including Physical Development/ Vision/Hearing.
2. Discharge Summaries
3. Psychological Reports
4. Social/Developmental History
5. Staffing Reports/Provider Notes
6. Medicaid Number (This will also be used to access information associated with the number that is needed to ensure diagnosis, treatment, and payment of services).
6. Private Insurance Number (This will also be used to access information associated with the number that is needed to ensure diagnosis, treatment, and payment of services.
7. Other (Specify)
8. All Information

Authorization

My signature below means I understand that:

√ My authorization to allow the sharing of information about my child is voluntary and expires upon exit from *Great Start* or my child's third birthday.

√ Information regarding behavioral and mental health services or communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Deficiency Syndrome or AIDS related complex) may be shared if I initial here ____ or if I list this type of information above.

√ Information received under this authorization becomes part of my child's educational record, is protected by the Family Educational Rights and Privacy Act (FERPA), and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPPA).

√ Information may be re-disclosed by *Great Start* as part of the educational record protected by FERPA.

√ I may refuse to sign this authorization.
- Refusal to sign may affect the ability of *Great Start* to obtain information necessary to demonstrate that my child meets *Great Start* eligibility criteria.
- If my child is found eligible for *Great Start*, refusal to sign this authorization will not affect my ability to obtain *Great Start* services. However, the information obtained can help provide services that are individualized for my child.

√ I may revoke or cancel consent at any time, without penalty, by notifying *Great Start* in writing. Information that has already been shared based on this authorization cannot be taken back.

I have read and understand this authorization form (or it has been read to me in a language I understand) and:

□ I authorize the above listed medical provider or designee to engage in verbal, written, and/or electronic communication in order to share specified records and information.

OR

□ I do not wish to have any information shared at this time.

Signature of Parent/Guardian:	**Relationship to Child:**	**Date:**