



Helping People...
Changing Lives

FLY Program/Peace of Mind EEC/HUMAN SERVICES, INC. (HSI)

CONSENT FOR THE RELEASE OF PRIVATE INFORMATION

CLIENT:

First Middle Last Born Month Day Year

AUTHORIZES:

FLY Therapeutic Preschool Program Staff & Screening Team Name & Contact Info. of person or organization

1825 Woodwinds Drive

Woodbury, MN 55125

651-232-6811

To Release to the Person or Organization Specified

To Release to FLY

(Yes or No must be checked in each category to be valid)

(FLY to Send)

(FLY to Receive)

Yes No

Yes No

\_\_\_ \_\_\_

Psychiatric Evaluation

\_\_\_ \_\_\_

\_\_\_ \_\_\_

Psychological Evaluation

\_\_\_ \_\_\_

\_X\_ \_\_\_

Treatment/Progress Report

\_X\_ \_\_\_

\_X\_ \_\_\_

Academic Records

\_X\_ \_\_\_

\_X\_ \_\_\_

Verbal Consultation

\_X\_ \_\_\_

\_X\_ \_\_\_

Other (Specify Below)

\_X\_ \_\_\_

Further specifications or explanations, such as condition or approximate dates of service:

\_\_\_\_\_

\_\_\_\_\_

This information is to be released for the purpose of:

\_X a) Continuing care, such as evaluation, treatment, ancillary services, and referral.

\_\_\_ b) Insurance Payment

\_\_\_ c) Other \_\_\_\_\_

I understand that I have the option to sign or not to sign this release and I may revoke this consent at any time with written notification, but that the revocation will not have any effect on information released prior to notification of cancellation. I understand that this consent will automatically expire one year from the date of my signature without my expressed revocation.

I understand that FLY cannot prevent the re-disclosure of records released as a result of this request. Therefore, FLY/HSI is released from any and all liability resulting from re-disclosure.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ (Client)

\_\_\_\_\_ (Parent/Guardian)

The information released pursuant to this consent should not be forwarded to another person or agency without the signed consent of the client.