Exchange and Release of Information Form

This form has been designed to facilitate communication between Hear Indiana and the child's primary care physician, ENT physician, pediatrician, audiologist/s, school personnel, teacher of the deaf, early interventionist/s, private therapist/s, and anyone else involved in the child's care.

When questions and/or concerns arise, please contact Hear Indiana immediately.

Child Name: ____DOB: ______________

HAAPI 4740 Kingsway Drive, Suite 33 Indianapolis, IN 46205 Ph: 317-828-0211 Fax: 888-887-0932	**RELEASE TO:** This section MUST be complete. Name: ______________________ Organization: ______________________ Address: ______________________ ______________________ Phone: ____________ Fax: ____________ Email: ______________________

I grant permission for the names listed above to receive/exchange information (includes written and/or verbal communication) if needed to secure, coordinate, and provide services to the individual listed above. This may include information regarding academic performance and health issues including emotional illness, drug or alcohol abuse, and HIV (AIDS/ARC) test results subject to the terms of Federal Law 42CFR, Part 2. This release is valid until either party requests termination in writing to Hear Indiana at the address listed above. Reports may be sent and received ONLY to/from the sources listed above. When sources are added or deleted, it is necessary to complete a new form. Separate forms must be filled out for each individual agency to which you wish to have records sent. Additional forms are available upon request. I understand that I have a right to revoke this authorization by providing written notice to Hear Indiana. However, this authorization may not be revoked if Hear Indiana, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my treatment, eligibility for benefits or enrollment, or payment for or coverage of services.

Parent Signature   Date

_______________________________   ____________

Parent Name (printed)

_______________________________   ____________