ATTACHMENT E

Early Intervention of Records Request and Authorization of Release Form

Early Intervention Records Request and Authorization of Release Form

Participant Identification Number: _____

REQUEST AND AUTHORIZATION OF EARLY INTERVENTION RECORDS RELEASE FORM

If you sign this document, you give permission to all early intervention providers listed on the attached sheet to release information that identifies your child for the research study described below:

> The *Natural History of Spina Bifida in Children Pilot Project* will contribute to the final design of a project that will examine what it is like to grow up with spina bifida. The pilot project seeks to determine the best ways to collect information about children with spina bifida. The project is currently conducting telephone interviews with parents, in-person assessments with children and parents, and abstracting information from the early intervention records of children with spina bifida.

The early intervention information that your child's early intervention providers may release for this research includes all information in your child's early intervention records (for example, type of services received, duration and frequency of services received). Specifically, the early intervention providers may release a copy of your child's entire early intervention records.

The early intervention information listed above may be released to: TBD TBD who works on the Natural History of Spina Bifida in Children Pilot Project.

The early intervention providers that you list on the attached sheet are required by law to protect your child's information. By signing this document, you authorize these early intervention providers to release your child's early intervention information for this research. Those persons who receive your child's early intervention information are not covered by the Federal HIPAA Privacy Rule. However, they will not release or share your child's information with anyone.

Your child's early intervention providers may not refuse to treat your child whether you sign this Authorization.

You may change your mind and take back this Authorization at any time except to the extent that your child's early intervention providers have already acted based on this Authorization. To revoke this Authorization, you must write to your child's early intervention providers.

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This authorization expires at the end of the research study.

Full Name of child: _____
First Middle Last

Child's Date of Birth: _____
Month Day Year

Name of Parent/Legal guardian: _____
First Middle Last

Signature of Parent/Legal Guardian: _____

Please provide the name/s, addresses, and telephone numbers of your child's previous and current early intervention program director below.

Name of Early Intervention Program Office:_____

Name of Program Director: _____

Address:_____

_____

_____

Phone: (_____) _____-_____

_____ _____
Signature of parent Date

_____ _____
Signature of witness Date