

## AUTHORIZATION TO RELEASE INFORMATION

Please complete this form to authorize \_\_\_\_\_ to disclose your contact information to qualified Early Steps providers that offer early intervention services and specialize in serving children with hearing loss. By signing below you authorize the release of your contact information only to facilitate the receipt of direct correspondence from service providers who specialize in serving children with hearing loss.

SECTION I. Contact Information		
Name		
Address		
City	State	Zip
Telephone number	E-mail Address	
SECTION II. Alternate Contact Information		
Name		
Address		
City	State	Zip
Telephone number	E-mail Address	
SECTION III. Authorization		
<p><b>EXPIRATION DATE:</b> This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.</p> <p><b>RE-DISCLOSURE:</b> I understand that once the above information is disclosed, it may be re-disclosed as specified above.</p> <p><b>CONDITIONING:</b> I understand that completing this authorization is voluntary. I understand that this disclosure does not constitute a referral to Early Steps. A referral to Early Steps may be made by contacting the Local Early Steps office serving my geographic area or by calling the Early Steps toll free number at 1-800-654-4440.</p> <p><b>REVOCAION:</b> I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I understand that I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.</p>		
Signature	Date	