



**For Infants and Toddlers- Birth through Two Years of Age Who May Need Early Intervention**

**Referral and Release Form**

**Community Centered Board:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

Child's Name: \_\_\_\_\_  Boy  Girl DOB: \_\_\_\_\_

Parent(s) / Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Family's Address: \_\_\_\_\_ County: \_\_\_\_\_

Primary Language Spoken by Parent(s)/Legal Guardian/Foster Parents:  English  Spanish  Other: \_\_\_\_\_

Foster Parent(s) (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_

Foster Parent(s) Address: \_\_\_\_\_ County: \_\_\_\_\_

How long has child resided at this residence? \_\_\_\_\_ Surrogate/ Advocate/ Guardian *ad Litem*?  YES  NO

If yes, Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Assigned DSS Caseworker: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Practice/Agency: \_\_\_\_\_ Referring Person: \_\_\_\_\_

Referring Person Phone: \_\_\_\_\_ Referring Person Fax: \_\_\_\_\_

Are you a Qualified Health Professional? (See *referral source guide for list*)  YES  NO If yes, Discipline: \_\_\_\_\_

Person to send referral status update to; if different:: \_\_\_\_\_ Fax; if different: \_\_\_\_\_

Has a developmental screening been completed for this child?  YES  NO If yes, Tool Used: \_\_\_\_\_

Please check and complete one of the following boxes (A or B):

**A.**  **This child has been diagnosed with the following physical or mental condition(s) known to have a high probability of resulting in significant delays in development (even if no delays are apparent at this time):**  
(See established condition database in the referral section on the EI Colorado website: [www.eicolorado.org](http://www.eicolorado.org))

**B.**  **There are concerns for possible delays in development in the following areas:** \_\_\_\_\_

Signed: \_\_\_\_\_ (referring person) Date of Referral: \_\_\_\_\_

I authorize \_\_\_\_\_ (referral source) to release the following information (check all that apply):

- Referral Information  Therapy Evaluations and Notes  Developmental Screening Results  Other: \_\_\_\_\_
- Admission Summary  Developmental Evaluations  Hearing Screen or Test Results  Other: \_\_\_\_\_
- Discharge Summary  Clinical Notes  Vision Screen or Test Results  Other: \_\_\_\_\_

**... to the Early Intervention Colorado program at the Community Centered Board (CCB) in our county of residence and the NICU Project (as appropriate) in order to establish my child's eligibility for early intervention services. I understand, in most cases, my information will be shared with the School District / Boards of Cooperative Educational Services responsible for my child in order to complete a child find screening and evaluation for my child.**

- I understand that signing this authorization is not a condition of receiving future medical treatment or early intervention services.
- I understand that I may revoke (i.e., cancel) this authorization at any time by notifying the Community Centered Board or School District (or BOCES) in writing, and that any information shared prior to revoking this authorization will not be affected by a revocation.
- I understand that before any specific services for my child are provided, I also have the right to authorize or decline those services.
- I understand that once released, my information may be disclosed and may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA), but will not be re-disclosed by the Community Centered Board or School District/BOCES, in accordance with the Family Educational Rights and Privacy Act (FERPA).

*For more information, see 45 CFR (Code of Federal Regulations) 164.508 for HIPAA and 34 CFR Part 99 for FERPA.*

This authorization expires on \_\_\_\_\_ (expiration date not to exceed one year from signature date)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  copy to parent(s) or legal guardian  
(child's parent or legal guardian)

I authorize Early Intervention Colorado to share the results of the early intervention eligibility determination process, including type and frequency of early intervention service(s) (as appropriate) with the above signed referring professional.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  copy to parent(s) or legal guardian  
(child's parent or legal guardian)