



Community Centered Board:

Child's Name: _____ Boy Girl DOB: _____
Parent(s) / Legal Guardian: _____ Phone: _____
Family's Address: _____ County: _____
Primary Language Spoken by Parent(s)/Legal Guardian: English Spanish Other: _____
Foster Parent(s) (if applicable): _____ Phone: _____
Foster Parent(s) Address: _____ County: _____
Primary Language Spoken by Foster Parent(s) English Spanish Other: _____
How long has child resided at this residence? _____ Surrogate/ Advocate/ Guardian ad Litum? YES NO
If yes, Name: _____ Phone: _____
Assigned DSS Caseworker: _____ Phone: _____

Name of Referring Person: _____ Agency/Practice: _____
Phone: _____ Fax: _____
Are you a Qualified Health Professional? (See referral source guide for list) YES NO If yes, Discipline: _____
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)

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 Physical Therapy Evaluations Developmental Screening Results Other: _____
 Admission Summary Occupational Therapy Evaluations Hearing Screen or Test Results Other: _____
 Discharge Summary Speech Therapy Evaluations Vision Screen or Test Results Other: _____

... to the following agencies and programs, and for the following reasons:

- Early Intervention program at the Community Centered Board (CCB) in our county of residence in order to establish my child's eligibility for early intervention services.
 Neonatal Intensive Care Unit (NICU) Liaison Project, as the single point of entry for level III NICUs, to facilitate the referral to the Community Centered Board in our county of residence in order to establish my child's eligibility for early intervention services.
 School District / Boards of Cooperative Educational Services (BOCES) or CCB responsible for my child in order to complete a child find screening and evaluation of my child, and/or (for children 27 months and older) to establish my child's eligibility for special education preschool services at three years of age.

-- 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)