

**NORTH LOS ANGELES COUNTY REGIONAL CENTER  
EARLY INTERVENTION PROGRAM**

**CONSENT FOR EXCHANGE OF INFORMATION**

**With your written consent**, community agencies and the persons they represent may share information with one another. This exchange of information helps us plan together and keep communication about your needs clear.

**You need to know that:**

- You choose which agencies shall exchange information.
- You may refuse to sign this exchange form.
- Information about your child and family is strictly confidential and will be released to those agencies and/or persons to whom you choose in writing.
- Information to be exchanged includes medical and health, developmental, speech and language, educational, hearing/vision and/or psychological.
- You have the right to review and inspect your child's records.
- You have the right to receive further written information about your rights.
- This consent is good for one year unless you withdraw it before that time.
- A photocopy of this will be considered/used as an original.

**PLEASE PLACE YOUR INITIALS NEXT TO AGENCIES WHICH MAY EXCHANGE INFORMATION:**

\_\_\_\_\_ California Children Services (CCS)                      \_\_\_\_\_ Los Angeles County Mental Health  
\_\_\_\_\_ Los Angeles County Public Health                      \_\_\_\_\_ Department of Public Social Services (DPSS)  
\_\_\_\_\_ Drug and Alcohol Program (DAP)  
\_\_\_\_\_ Department of Children and family Services (DCFS)  
\_\_\_\_\_ Primary Physician: (Name): \_\_\_\_\_  
\_\_\_\_\_ Local Education Agencies (Specify)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Other school districts, agencies, programs, or persons  
\_\_\_\_\_  
\_\_\_\_\_

I agree that information about my child may be exchanged among the agencies initialed above and the persons who represent them. I understand that I may limit what information is exchanged. Please list any limitations:

\_\_\_\_\_  
**Name of child:**

**Date of birth:**

\_\_\_\_\_  
**Parent/legal guardian**

\_\_\_\_\_  
**Date**

