



## Medical Home–Early Intervention Information Referral/Release

**This form will authorize the exchange of information between this child’s Medical Home Provider and the Early Intervention Program**

When completed, this form should be handed, mailed, or faxed to your local [Early Intervention Program](#)

Release of information	Child’s First & Last Name:	Parent/Guardian’s Name:	Address:
			Phone:
	Early Intervention Program:	Address:	Phone Number:
			Fax:
	I, the undersigned, authorize the release of information relating to the diagnosis/condition listed below regarding the above-named child to the early intervention program and appropriate early intervention providers AND authorize the early intervention program to release and discuss information and reports with the named physician and/or his/her assigned office personnel.		
Parent/Guardian’s Signature	Date:	If applicable, my consent expires:	
Information or records not be released include:			

Physician contact info	Medical Home Provider (MD, DO, PA, NP) Name:	Phone Number:	Fax Number:
	Mailing Address:	Email Address:	
	Preferred Method and Time for Contact:		

Diagnosis/ Screening Information	Reason for Referral, Screening Results, and/or Concerns:	
	Most recent evaluation of the following: Well Child Exam, date: _____; relevant findings:	
	Vision exam, date: _____; relevant findings: Hearing exam, date: _____; relevant findings:	
	Medical Home Provider Signature:	Date:

### To be completed by Early Intervention and returned to the Medical Home Provider

E.I. Follow up	Eligible: <input type="checkbox"/> yes _____ _____
	<input type="checkbox"/> no _____ _____
Eligibility Form Attached <input type="checkbox"/>	IFSP Attached <input type="checkbox"/>