



## Authorization to Disclose Information

Child's Full Name: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the disclosure of information for the purpose of early intervention services from The Bell Center for Early Intervention Programs to the following medical professionals, early intervention providers and/or others as indicated:

Name	Address	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization will expire one year from the date of signature.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date