PROVIDENCE Children's Health

AUTHORIZATION FOR MUTUAL EXCHANGE OF EDUCATIONAL INFORMATION

Patient Name: ____ Date of Birth: ______________

The child named above has been referred to the Providence Children's Development Institute. Please provide us with all special education testing including, but not limited to, the following:

- EI/ECSE/IEP/IFSP/504 plan (even if expired)
- Psychoeducational Assessment
- Academic/Achievement assessment
- Communication Assessment
- Motor Coordination – Occupational and Physical therapy
- Eligibility Statements
- Disability Assessment
- Behavioral Assessment

I/we hereby authorize mutual exchange of information between
Providence Children's Development Institute

830 NE 47th Avenue
Portland, OR 97213
Phone: 503-215-2233
Fax: 503-215-2456

9135 SW Barnes Road Suite 561
Portland, OR 97225
Phone: 503-216-2339
Fax: 503-216-6813

310 Villa Road Suite 106
Newberg, OR 97132
Phone: 503-537-3546
Fax: 503-537-3545

AND

Name of School/School District____

Street Address____

City ______________________________ State__________ Zip Code_______________Email_______________________

Phone Number ___________________________________Fax____

The information above is to be exchanged for coordination of care. If not revoked, this authorization will expire 3 years from date signed.

____________________________________ Legal Guardian (Print Name)

____________________________________ Relationship to patient

____________________________________ Legal Guardian Signature

____________________________________ Date

____________________________________ Patient Signature **Only required if patient 13 years or older*

____________________________________ *Date*

I understand and agree that mental health specific information is covered by this release.

Patient Initials Required if 13 years or Older ________ Legal Guardian Initials ________