# HAMILTON COUNTY PUBLIC HEALTH NURSING SERVICE

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Like us on Facebook: Hamilton County Public Health Nursing Service

## Hamilton County Public Health Nursing Service

Consent to Disclose Personally Identifiable Information

Disclose: Releasing/Obtaining information from another agency and receiving same information

I hereby consent that Hamilton County Public Health Nursing Service may release personally identifiable information to the agency created on behalf of:

Student/Child Name: _____ Date of Birth: _____

Address: _____

Information that is released is limited by the agency/ies you choose. Please list below. (For example, you may list the school and Dr. and they will be the *ONLY* agencies to which information is disclosed.)

Agency: _____

Address: _____

Specify the part of the record to be disclosed:

- o Service Coordinators Documents
- o Individual Family Services Plan (IFSP)
- o Other (must be specific)

_____

Agency: _____

Address: _____

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- o Individual Family Services Plan (IFSP)
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Agency: _____

Address: _____

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- o Individual Family Services Plan (IFSP)
- o Other (must be specific)

_____

Covering the period(s) of service from (dates): _____-_____

Signature of Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

*Any Personally Identifiable Education Information released must be accompanied by the Re-Disclosure Warning Sheet for confidentiality if faxed or mailed.