Maine Autism Institute
for Education and Research

THE UNIVERSITY OF MAINE

5766 Shibles Hall, Room 303
Orono, Maine 04469-5766
Tel: 207.581.2358
Fax: 207.581.2428
maineautisminstitute@maine.edu
umaine.edu/autisminstitute/

Consent for the Release of Information

_____ (Child's Name) _____ (DOB) is receiving intervention using the Early Start Denver Model (ESDM) from trained early interventionists, in partnership with the Maine Child Development Services (CDS) and the Maine Autism Institute for Education and Research (MAIER).

I hereby authorize MAIER and CDS personnel to exchange verbal and/or written information about my child. I understand that the child/family records are protected under state and federal confidentiality regulations and cannot be disclosed without written consent. I understand that all information about my child and the ESDM intervention will be shared with me.

In addition, for the purpose of research, I understand that data about my child may be shared with MAIER staff, University of Maine research faculty, local and state stakeholders, as well as early intervention and early childhood publications for disseminating the results. No identifying information about my child will be shared.

I also give permission for the following:

___ MAIER staff to video record ESDM sessions with my child. The video will be used for training and research purposes and will be shared only with MAIER staff, unless further permissions to share are obtained.

This consent is voluntary and I understand that I can withdraw my consent for my child at any time. Unless I withdraw this consent, it will expire automatically one year from the date signed below.

By signing below, I am confirming that I have read, understood, and agree to the above.

Date Signed _____

Parent/Caregiver Name: (Print full name)

_____

Parent/Caregiver Name: (Signature)

Mailing Address City, State, Zip _____

_____

Telephone _____

Email _____

Please circle the type of communication you prefer: Phone Email

Child's Name:	Gender:
DOB:	Age:
Dx:	
Parent/ Guardian Name: Address: Phone:	
Primary Health Provider: Phone:	
Preschool/ Childcare: Contact: Phone:	
Service Coordinator: Phone: Email:	
Primary Service Provider: Phone: Email:	

Service Currently on IFSP

Early Intervention Services	Location of Services	Method of Service Delivery	Frequency/Intensity	Funding Source