Rockland County HEALTH

EI-TR-04

NYEIS Child Reference #_____

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

CONSENT FOR TRANSMITTAL OF EIP EVALUATIONS AND RECORDS

DATE:	Date of Referral to the EIP:
Child's Name: Last First	Child's Date of Birth: Child's Age (year-month)
Name of Parent/Legal Guardian/Surrogate: Last First	Phone No.
Home Address:	School District:
Service Coordinator:	Phone No. Fax No.
CPSE Chairperson:	Phone No. Fax No.

Please Read

I understand that the CPSE may use evaluation reports and other EIP records, which I may choose to share, as part of the CPSE evaluation process. I decide what records to share, if any. If I consent to share these records, the CPSE will review them and will decide if other evaluations are necessary to decide if my child is eligible for preschool special education programs and services. I understand that if the CPSE asks for more evaluations, I will be asked for my consent for the CPSE to evaluate my child. I understand that if I do not consent to evaluations asked for by the CPSE, and my child is not evaluated by the CPSE and is not determined eligible for preschool special education programs and services by my child's third birthday, EIP services will end the day before my child turns three years old.

Consent to Transmit Early Intervention Program Evaluation and Program Records to the CPSE

☐ **I give my consent to my service coordinator** to transmit the following EIP reports and records to the CPSE of the school district in which my child resides:

_____
_____
_____

☐ **I do NOT give consent** to my service coordinator to transmit EIP records and reports to the CPSE of the school district in which my child resides**. I understand that my child must be referred to, evaluated by, and, before the day s/he turns three years of age, be found eligible by the CPSE for services, to continue to receive Early Intervention Program services on and after s/he turns three years of age.**

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Parent Name Parent Signature Date