



**PARENT PERMISSION FOR 24-HOUR POSTURAL CARE PROJECT SERVICES AND
CONSENT TO THE RELEASE OF PERSONALLY IDENTIFIABLE INFORMATION**

I am the parent/guardian of _____.

I give permission for my child's team,

- To request and receive consultation services from the 24-Hour Postural Care Project.
- To exchange information from my child's records with the 24-Hour Postural Care Project and related UVM personnel for use during the consultation and related planning.

I understand that:

- The 24-Hour Postural Care Project services may include such services as talking with me and with service providers about my child's needs; observation of my child in home, school, and/or community settings; participation in team meetings; providing relevant resources; and providing training and/or recommendations.
- There is no cost to my family for these services.
- The 24-Hour Postural Care Project will observe confidentiality requirements.
- The 24-Hour Postural Care Project will continue on an ongoing basis, unless the team no longer needs consultation.
- I may revoke this consent in writing at any time in the future if I no longer wish to use the 24-Hour Postural Care Project services.

Signature of Parent/Guardian: _____ Date: _____

Print Parent/Guardian Name:

Language used in the home: _____



Additional Consents:

1. Consent to Release of Medical and/or Other Third-Party Information:

To assist the 24-Hour Postural Care Project and my child's team in planning and implementation of services for my child, I give permission to the 24-Hour Postural Care Project and my child's team to communicate and share records and information regarding my child, to the individual(s), agency(ies), or organization(s) named below, or for person(s)/organization(s) named below to disclose information and/or records regarding my child to the 24-Hour Postural Care Project and team.

Child's Name: _____

Name(s) of Person, School, Physician, Agency or Other Third Party(ies):

Parent or Guardian Signature: _____ Date: _____

2. Use of e-mail:

I consent to the use of e-mail for confidential correspondence between the 24-Hour Postural Care Project, members of the child's team, and me.

Parent/Guardian signature: _____ Date: _____

3. Photographs and recordings for use by the 24-Hour Postural Care Project:

I consent for the 24-Hour Postural Care Project to photograph, record, and/or video my child to assist in determining and providing recommendations and implementation. These items will only be shared with the 24-Hour Postural Care Project members and team members involved in planning and/or implementing my child's programming.

Parent/Guardian signature: _____ Date: _____