Alcott School
Early Intervention
535 Broadway, Dobbs Ferry, NY 10522
Phone (914)693-7677 Fax (914)693-0386
E-Mail: mconnolly@alcottschool.org

Parental Consent for Evaluation and Release of Information
SUPPLEMENTAL Evaluation

Child's Name:_____DOB: _____

Circle the appropriate response.

Yes No I have received an explanation of the evaluations that are being offered to my child.

Yes No I consent and authorize the Alcott School to evaluate my child to determine if my child is eligible for Early Intervention services through the Westchester County Department of Health.

I consent to have the reports released to:

Yes No The ongoing Service Coordinator;
Yes No The EIOD from the Westchester County Department of Health;
Yes No My child's primary care physician at: _____
_____
(doctor's name and address)

Yes No My child's early intervention providers.
Yes No I consent to have the evaluations e-mailed to me from the Alcott School. I have read, signed and understand the risks that have been outlined for me on the ***Parental Consent to Use Email to Exchange Personally Identifiable Information***.

_____
Parent/Guardian Name (please print) Relationship to Child

_____
Parent/Guardian Name (please sign) Date