Instructions for Completing ATP Form

Authorization for Release of Records and Information

Use

The ATP Release Form is used by technology specialists or other ATP staff to obtain authorization from the consumer with disabilities or from the parent, guardian or representative of the consumer to request from, and release information to specified agencies, programs, or identified persons.

Completion

Provide identifying information as indicated.

Release of or Request for Information

Obtain **consumer/representative's initials** by specified agencies, programs or persons from which information can be released to the technology specialist or other staff and with which information collected from previously identified agencies can be shared. The purpose for this exchange of information is to enable the technology specialist or other ATP staff to help coordinate services, provide appropriate referrals, to make sure the consumer gets services as quickly as possible, and to respond to requests of others for documents and information regarding the referral to ATP and services from ATP.

Signature

Obtain **consumer/representative's signature** and identifying information as indicated.

Validity Dates

Authorization may be valid for one year from **date of signature** unless otherwise noted.

Distribution

The original of the Release Form is maintained in the ATP record. A copy is made and forwarded to the parent/representative. Additional copies are used to request information from specified agencies.

Retention

The Release Form is retained in the ATP record for six years after the completion of the activities.

Authorization for Release of Records and Information

INITIATING OFFICE	CONTACT PERSON
OFFICE ADDRESS	PHONE

CONSUMER FULL NAME	DATE OF BIRTH
ADDRESS	PHONE
CITY/STATE/ZIP	CELL

I give my consent to the Assistive Technology Partnership to disclose documents and information in order to coordinate services, provide appropriate services, make sure services are provided as quickly as possible, and in response to requests of others for such documents and information as noted below.

I have written my initials next to the agency, programs, or persons that I authorize ATP to disclose information and documents regarding my referral to ATP and services from ATP.

This authorization authorizes ATP to disclose those listed below all documents described above unless otherwise noted.

Agency/Program/Person (specify)	**Initials**

1) I have the right to withdraw my consent at anytime.
2) I am providing my consent voluntarily.
3) I understand the information on this form.
4) If I do not give my consent to share information, the agencies involved may not able to determine the best services available for me and my family.
5) ATP may disclose records without my consent if required by law or in response to a lawfully issued subpoena.

SIGNATURE (CONSUMER, PARENT, GUARDIAN, REPRESENTATIVE) **RELATIONSHIP TO CONSUMER** (IF APPLICABLE) **DATE**

This release is valid for one year from date above unless otherwise noted. Information shared by those listed above will not be disclosed to anyone else without written consent of the consumer, parent, guardian, or representative.

Original retained
Copy to consumer

2. 2011 and revised 3.2017