Vermont Continence Project

PARENT/GUARDIAN PERMISSION FOR CONTINENCE PROJECT CONSULTATION

I am the parent/guardian of _____.

I give permission for my child's team,

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

I understand that:

- **Continence 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, daycare, 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 **Continence Project** will observe confidentiality requirements.
- The **Continence 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 **Continence Project** services.
- By signing this form, I represent that I have the full legal authority to consent to the above on behalf of the child named.

Parent/Guardian Signature: _____Date:_____

Print Parent/Guardian Name: _____

Language used in the home: _____

(see reverse)

CONSENT TO THE RELEASE OF PERSONALLY IDENTIFIABLE INFORMATION

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

To assist the **Continence Project** and my child's team in planning and implementation of services for my child, I give permission to the **Continence 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, and for person(s)/organization(s) named below to disclose information and/or records regarding my child to the **Continence Project** and team.

Child's Name:_____
Please **name specific parties** with whom you consent to release of information:

____ **School:**

____ **Physician:**

____ **Mental/Community Health Provider:**

____ **Outpatient Therapies (PT, OT, etc):**

____ **Other:**

Parent/Guardian Signature: _____Date:_____

2. Use of e-mail:
I consent to the use of e-mail for confidential correspondence between the Continence Project, members of the child's team, and me.

Parent/Guardian Signature: _____Date:_____

3. Photographs and recordings for use by the Continence Project:
I consent for the Continence 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 Continence Project members and team members involved in planning and/or implementing my child's programming.

Parent/Guardian Signature: _____Date:_____