CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

I, ______________________________ , consent to the disclosure of my infant's inpatient or outpatient hearing screening or other audiological test results, demographic and contact information, including identifying and contact information for myself and a secondary contact, to the State of California Newborn Hearing Screening Program and its designated Hearing Coordination Centers (henceforth referred to as NHSP). I have been informed and understand that the NHSP will use this information in accordance with Health and Safety Code Division 106, Part 2, Chapter 3, Article 6.5 §§ 124115 et seq. and NHSP standards to assist my child in accessing needed screening, diagnostic, treatment and early intervention services related to hearing loss. I understand that the NHSP may further disclose the above information to other parties for the purposes herein. In addition to the NHSP, recipients of this information may include hearing screening and audiology providers, physicians or other health care providers, the local California Children's Services program (State and local program that pays for specialized health care services for children with eligible conditions including hearing loss), the Early Start Program (provides developmental supports and services to infants and toddlers with disabilities and their families) and the Child Health and Disability Prevention Program (assists in locating and contacting families to avoid loss to follow up).

This consent expires when my child reaches one year of age. I understand that I may revoke this consent at any time by contacting the NHSP Hearing Coordination Center serving my child at 1-877-388-5301 and requesting that no further action be taken by the NHSP on behalf of my child. I understand I will need to provide sufficient information to confirm my identity and that of my child.

Signature: ____

Date: ____

Infant's Name: ____

Infant's Date of Birth:____