Authorization for Release of Information
– Children's Inclusion Support Services

Child's Name: _____ Date of Birth: _____
(Month/Day/Year)

I _____ authorize the release of the most recent assessment report(s).
(name of parent/guardian)

(as indicated below) completed on the above named child, to be sent to Children's Inclusion Support Services. This is for the purpose of planning for the inclusion of my child in a community child care program.

Please select the appropriate box(es).

Children's Hospital of Eastern Ontario (CHEO)

- ☐ Speech/Language
- ☐ Audiology
- ☐ Blind/Low Vision
- ☐ Physiotherapy
- ☐ Occupational Therapy
- ☐ Psychological/Developmental
- ☐ Neurology

If more than one service (identifiable services listed under Other) is able to provide assessment information, please submit another form by photocopying or downloading a copy of this form from our website at www.afchildrensservices.ca

Other

☐ Other, such as child's paediatrician, private therapist(s), etc.
Please provide full name, phone number & email address

_____

_____

_____

You are asked to please send CISS medical information such as assessments, letters confirming diagnosis, summary of the assessment along with this completed form. If your child's medical information is with CHEO, please note you can access it through CHEO MyChart by following this link: https://mychart.kidshealthalliance.ca/mychart/Authentication/Login

☐ **Please select if medical Information is attached.**

Signature: _____ Date: _____
(Month/Day/Year)

Relationship to child named above: _____

Please return to: **Children's Inclusion Support Services**
cissintake@afchildrensservices.ca

This form is valid for a period of ninety (90) days.