

**NEW JERSEY EARLY INTERVENTION SYSTEM (NJEIS)**  
**CONSENT TO RELEASE/ OBTAIN INFORMATION**

Child's Full Name: \_\_\_\_\_ NJEIS ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City/Town: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Parent/Guardian Email: \_\_\_\_\_

I, (Print Parent/Guardian Full Name): \_\_\_\_\_, seek services for my child from the NJEIS. I understand that it may be necessary for the practitioners (including evaluators, provider agencies, and service coordinators) offering Early Intervention (EI) services to my child and family may need to exchange information to develop and fulfill the services on the Individualized Family Service Plan (IFSP). The information will be part of this child's record maintained in the NJEIS Early Intervention Management System (EIMS), or county Service Coordination Unit based on where the child resides.

**Purpose of Information Requested**

Parent consent is being requested to obtain essential and necessary information to plan and provide early intervention services. The NJEIS provides services to children with developmental delays and disabilities, from birth to age three, and their families. This consent is subject to the provisions of the Family Educational Rights and Privacy Act (FERPA).

**Consent Options:**

**INFORMATION FOR RELEASE IS LIMITED TO THE FOLLOWING ITEMS: I authorize the information below to be released (shared).**

<b>Please initial each item for which you are providing consent:</b>	<b>Please check all that apply</b>	<b>Initials</b>
Referral and Intake Information:		
NJEIS Eligibility Determination Summary:	✓	
Developmental Evaluation/Assessment Reports and Testing Protocols:	✓	
Individualized Family Service Plan (IFSP):	✓	
Service Practitioner/Caregiver Notes:		
Medical Records (e.g., progress notes, treatment plans):		
Other (Please Specify)		

**INFORMATION TO BE OBTAINED IS LIMITED TO THE FOLLOWING ITEMS: I authorize the information below to be obtained (collected).**

Please initial each item for which you are providing consent:	Please check all that apply	Initials
Referral and Intake Information:		
NJEIS Eligibility Determination Summary:	✓	
Developmental Evaluation/Assessment Reports and Testing Protocols:	✓	
Individualized Family Service Plan (IFSP):	✓	
Service Practitioner/Caregiver Notes:		
Medical Records (e.g., progress notes, treatment plans):		
Other (Please Specify):		

I authorize the above initialed information to be:

**A. Released to All NJEIS Providers:** (Regional System Point of Entry (SPOE), Service Coordination Units (SCU), and Early Intervention Provider Agencies (EIP) providing evaluation/assessment, service coordination, or services to my child and family. NJEIS is not permitted to re-disclose the records listed above to a third party without seeking your additional written consent.

**B. Released to the Individual/Agency:**

Individual Name: Audrey Mars MD Agency Organization Name: Developmental Pediatric Associates  
Address: 190 Route 31 suite 500 City: Flemington, NJ Zip: 08822  
Phone: 908-788-6650 Extension:        Fax: 908-788-6581 Email: amars@hhsnj.org

**C. Obtained from Individual/Agency**

Individual Name: \_\_\_\_\_ Agency Organization Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Extension: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**The information will be sent to:**

Individual Name: \_\_\_\_\_ Agency Organization Name: \_\_\_\_\_ DevelopmentalPediatricAssociates

Address: 190 route 31 Suite 500 City: Flemington Zip: 08822

Phone: 908-788-6650 Extension: \_\_\_\_\_ Fax: 908-788-2578 Email: \_\_\_\_\_

**Authorization Details**

Expiration Date: \_\_\_\_\_ (if earlier than one year from today).

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If applicable:**

Print Interpreter Name: \_\_\_\_\_ Interpreter Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Important Notes**

- You can revoke or modify this consent anytime by providing written notice to your Service Coordinator.
- A copy of this signed form holds the same force and effect as the original.
- A new Consent to Release/Obtain form is required at each IFSP review or annual meeting.

**The New Jersey Early Intervention System (NJEIS) & the New Jersey Department of Child**

**Protection and Permanency (DCPP) work collaboratively:** in accordance with the Individuals with Disabilities Education Act (IDEA) Part C, with the child and resource parent to:

- Address questions, model activities, and provide strategies to support the child's developmental needs in daily routines.
- Conduct ongoing assessments and monitor the child's developmental progress; and
- Evaluate areas of the child's development consistent with early intervention policies and practices, utilizing the child's natural environment.

I, [REDACTED] the biological parent of the child [REDACTED], understand that I retain all procedural safeguard rights under New Jersey law and Part C of IDEA. However, I authorize the resource parent, as designated by DCPP, to coordinate, attend, and participate in all Early Intervention Services for the child, as determined necessary by the evaluation process and documented in the Individualized Family Service Plan (IFSP).

Biological Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Biological Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that this consent does not constitute a waiver of my procedural safeguards rights under IDEA and/or Family Educational Rights & Privacy Act (FERPA). I retain the ability to access my child's early intervention records and may revoke this consent at any time by submitting a written request to the Service Coordination Unit.

Service Coordinator Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_