Release Form

Firstep Evaluations

Please fill out all below fields

I _____ give my consent that

Firstep may forward my child_____ 's

records to the designated physician/individual/agency indicated below.

I authorize Firstep to obtain medical information from my child's physician.

Please check if applicable: ***(Please include address & phone number)***

○ ***Physician:*** _____

_____

_____

○ ***School:*** _____

_____

_____

○ ***Headstart:*** _____

_____

_____

Contact Person _____

○ ***Early Intervention: (if applicable)*** _____

_____

_____

Coordinator _____

○ ***Other:*** _____

_____

_____

Signature of parent or guardian: _____ Date: _____