



Early Childhood Consultation and Outreach (ECCO)
Consent and Authorization for Release of Information

Name _____

Address _____

City _____ State _____ Zip _____

Date of birth _____

I hereby authorize Community Caring Collaborative, its authorized employees, agents and partners, to obtain from and share information regarding me and my child(ren) with the organization, agency, or individuals named below.

Individual or Agency	Phone Number or Address
_____	_____

I understand that:

- Information shall be shared only on a need to know basis in order to work cooperatively with others on my or my family's behalf.
- I may revoke this authorization at any time wither verbally or in writing, except to the extent that action has been taken in reliance on this authorization.
- If not revoked, this authorization will terminate one year from the date of my signature unless I have specified a different expiration date or event:

_____	Date _____
Signature	

_____	Date _____
Witness Signature	

At this time, I wish to remove the following agency, organization or individual from this release.

Agency / organization / individual name (print)

_____	Date _____
Signature	

_____	Date _____
Witness Signature	

Please mail or fax Consent form to:

Community Caring Collaborative
Attn: Julie Redding, LCPC
225 Shattuck Road, Calais ME 04619
Cell: 207.214.8434 Fax: 207.952.9182