





**CHAMPION**  
Autism Therapy Center

3055 Old Hwy 8, Suite 190  
Saint Anthony, MN 55418  
TEL: 612-345-7659  
FAX NUMBER: 612-605-6300

**Consent for Release of Confidential Information**

Date: \_\_\_\_\_

Child's Name:

\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent/Guardian/Caregiver Name: \_\_\_\_\_

I hereby give my informed consent for the following individual/entity:

\_\_\_\_\_

to release and exchange the following information with Champion Learning Center for the sole purpose of care and coordination and treatment planning services.

The information being requested includes (please circle):

Psychological reports and testing

Diagnostic Assessment(s)

Medical Record/Most recent well-child check

Transition and Discharge Summary

Initial Individual Education Plan and updates

Comprehensive Multidisciplinary Evaluations (CMDE)

Individual Treatment Plans (ITP)

Consumer Support Plans (CSP)

Other (specify): \_\_\_\_\_

***This consent expires one year from the date signed unless consent is withdrawn before that date.***

By signing I acknowledge that I have been informed as to who will receive the information, what information will be released/exchanged, and what the information will be used for. I understand that information will not and cannot be released without my consent. The information that will be released is private and confidential. All information being released/exchanged in governed by the Minnesota Government Data Privacy Act (Minn. Stat. Chap 13, as amended) and the Health Insurance Portability and Accountability Act (HIPPA). I understand that I may withdraw my consent at any time by giving written notice.

\_\_\_\_\_  
(Parent/guardian/caregiver Signature)

\_\_\_\_\_  
Date