

NYC EARLY INTERVENTION PROGRAM
PARENTAL CONSENT TO OBTAIN/RELEASE INFORMATION

Child's EI ID No. _____ Child's DOB: ____/____/____

Child's Name: _____
Last First

Address: _____ Apt. No. _____
Street

City Town State Zip Code _____

I, _____, give my consent to have my child's
Name of Parent/Guardian (Please print)

records released by _____ and sent
Name of Provider Releasing Information

to **Marion K. Salomon & Assoc.**
Name of Provider Requesting Information
125 E. Bethpage Rd. Suite 5 Plainview, NY 11803
Address of Provider

of the purpose of determining an appropriate early intervention evaluation, placement,
and/or services for my child.

Signature of Parent/Guardian

Date Signed

NOTE: A reproduced copy of this signed form is deemed to have the same force and effect as the original.