

## Consent and Release of Information Sample

\_\_\_\_\_ Date

Dear Parent/Caregiver of \_\_\_\_\_ (name of child),

A free **hearing/vision** screening will be given. The purpose of this program is to find potential problems so treatment can be given. The results of this screening will be entered into ImpactSIIS, the secure Ohio immunization information management system. This is only a screening. It is recommended that you take your child to his/her primary health care provider ("health home") for further evaluation. If you have any questions concerning the screening results, please contact: \_\_\_\_\_ .

Please check Yes or No:

YES, I want my child screened and results entered in ImpactSIIS. (Please fill in the entire form, sign below and return form.)

YES, I want my child screened but I do NOT want results entered in ImpactSIIS. (Please fill in the entire form, sign below and return form.)

NO, I do not want my child screened and results entered in ImpactSIIS. (Please fill in the entire form, sign below and return form.)

I, \_\_\_\_\_ (*parent/guardian*) of the above named child, hereby authorize the provider completing this report to submit all records pertaining to immunizations status and screening results to the ImpactSIIS, the Ohio immunization information management system. I understand that I may refuse to sign this authorization and that my refusal will not affect screening services provided to my child.

***This is provided as a sample. Please consult with your legal advisor.***