

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

_____ Zip Code _____
City Town State

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 Los Niños Services, Inc.
Name of Provider Requesting Information

2489 Broadway 2nd Fl., New York, NY, 10025
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.