Dear Upstate KIDS: Infant Development Screening Program Participant,

Thank you for your participation in this important screening program.

During the course of the 'Upstate KIDS Infant Development Screening Program' we will be learning a great deal about your child’s growth and development and would like to be able to have periodic contact with your child’s physician to obtain relevant medical information from them. We cannot communicate with your child’s primary care provider or obtain medical information from them unless you provide us with permission to do so. By signing the attached form, entitled 'Authorization Form for Physician Medical Release of Information,' and including the name/contact information of your child's physician, you will be granting us permission to obtain relevant medical information collected during routine visits and check-ups.

Additionally, as researchers, we cannot release to your child's primary care provider any survey information you provide us unless you permit us to do so. The second attached form, entitled 'Authorization for Release of Survey Information,' allows us to release your survey results to the physician specified. Please sign this form and fill in the required information if you agree to these terms.

If you have any questions about these forms or about any aspect of the 'Upstate KIDS Infant Development Screening Program', please do not hesitate to call the Program’s Principal Investigator:

Dr. Charlotte Druschel
Bureau of Environmental and Occupational Epidemiology
New York State Department of Health
547 River Street
Flanigan Square
Room 200
Troy, NY 12180
Telephone: 1-888-870-0247

or myself, the Upstate KIDS Program Coordinator:

Ms. Elaine Hills,
New York State Department of Health
One University Place, Room 216,
Rensselaer, NY 12144,
Telephone: 1-888-870-0247

Thank you again for working with us to understand and improve children’s health and wellbeing,

Elaine A. Hills, MA
Program Coordinator
Authorization Form for Release of Survey Information

I authorize researchers collaborating on the 'Upstate KIDS Infant Development Screening Program' to disclose the following protected health information to my child's primary health care provider:

*Evaluations from data collected over the course of the 'Upstate KIDS Infant Development Screening Program' deemed important to share for the child's well-being.*

1. ___________________________ 2. ________________
   Name of patient       Date of birth

3. ___________________________ 4. ________________
   Street address, city, state, zip       Phone number

Information to be disclosed to:

5. ___________________________ 6. ________________
   Name of your child's pediatrician       Phone number of pediatrician’s office

7. ___________________________ 8. ___________________________
   Name of pediatrician’s clinic       Address of pediatrician’s clinic

9. The above information is disclosed for the following purpose: Research

10. This authorization expires on [upon]: 9/4/2012.

I understand I may revoke this authorization at any time by requesting such of the above referenced hospital in writing, unless action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state laws protecting confidentiality.

11. Your Signature       12. Today's Date

Relationship to patient or authority to act for patient

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED.

PLEASE COMPLETE AND RETURN THIS FORM IN THE POSTAGE PAID ENVELOPE PROVIDED
Authorization Form
for
Physician Medical Release of Information

1. I authorize __________________________________ at ______________________________
   Name of Pediatrician     Name of Doctor's Office/Clinic
located at _________________________________________________________________
   Full Address of Pediatrician’s Office/Clinic

to disclose protected health information from my child's medical record.

2. _____________________________________   3. ______________________
   Name of patient          Date of birth

4.______________________________________  5.________________________
   Street address, city, state, zip        Phone number

Information to be disclosed to:
   Dr. Charlotte Druschel, MD, MPH
   Bureau of Environmental and Occupational Epidemiology
   New York State Department of Health
   547 River Street
   Flanagan Square
   Room 200
   Troy, NY 12180

6. The above information is disclosed for the following purpose: Research

7. This authorization expires on [upon] 9/4/2012

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referenced physician/clinic in writing, unless action has already been taken in reliance upon it.

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re-disclosure by the recipient and, if so, may not be subject to federal or state laws protecting
confidentiality.

8. Your Signature    9. Today's Date

Relationship to patient or authority to act for patient

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