Karen B. Salmon, Ph.D.
Acting State Superintendent of Schools

MARYLAND STATE DEPARTMENT OF EDUCATION
PREPARING WORLD CLASS STUDENTS

200 West Baltimore Street • Baltimore, MD 21201 • 410-767-0100 • 410-333-6442 TTY/TDD • msde.maryland.gov

AUTHORIZATION FOR RELEASE OF INFORMATION

Parent/Guardian's Name: _____
Child's Name: _____
Child's Date of Birth: _____

Provider: Maryland State Department of Education (MSDE) Early Childhood Mental Health Project
Name of Provider: Arundel Child Care Connections, Inc. 44 Calvert Street, Room 140 A
Annapolis, Maryland 21401
Name of Child Care Provider: _____

Requestors: The Early Childhood Mental Health Project (ECMH) is funded through the MSDE. The MSDE is requesting that all of its grantee programs collect certain information about program participants. Local programs collect the information by entering it into the MSDE Outcome Monitoring System (OMS).

Information Requested: The Participant identified above authorizes the local ECMH program to collect the following information on behalf of MSDE:
 Child's name, date of birth, sex, race, ethnicity, parent's name, child care facility information, date and source of referral, service time, screening summary information from child and parent surveys, and if child receives/d public school services-IFSP or IEP. Other information such as social status will be requested, but will not be made a part of any identifiable record or linked to a specific participant.

Purposes of Release: For the purposes of evaluating, reviewing, and monitoring the Maryland State Department of Education's Early Childhood Mental Health Consultation Project (ECMHP) as part of the state's longitudinal data system.

Your right to inspect/amend/correct these records. Any participant has the right at any time to inspect their information that was collected by the ECMHP grantee for MSDE.

Who has access to this information?
Personally identifiable information will not be available for public inspection. Personally identifiable information the ECHMP grantee collects will only be shared with the MSDE for the purposes described above in this release.

Revocation: I understand that I may revoke this authorization at any time, by giving written notice to the Early Childhood Mental Health Consultant, at the address mentioned above. I understand that revocation is only effective after the written notice is received by MSDE, and that any use or disclosure of the information under this authorization, made before the revocation is effective, will not be affected by the revocation. I understand that I may elect to have my child continue receiving services through ECMH without having his/her data shared.

Copies provided: I understand that I am entitled to receive a copy of this authorization.

Original not required/copy equivalent to original: Any facsimile, copy or photocopy of the authorization authorizes the release of all records requested herein.

Any questions or concerns about the contents of this release or the information requested may be directed to the ECMH Grant Monitor at 410-767-8959.

I give authorization for my child's personal identification to be entered into the Online Monitoring System (OMS).

Signature of Parent/Guardian: _____

Date: _____

I deny authorization for my child's personal identification to be entered into the Online Monitoring System (OMS).

Signature of Parent/Guardian: _____

Date: _____