RESET BUTTON

PARENT TO PARENT
OF PENNSYLVANIA

1-888-727-2706

AUTHORIZATION TO RELEASE INFORMATION FORM

Date: _____

REFERRING AGENCY /COUNTY:_____

If participating in the Early Intervention Direct Referral program, please check one of the boxes below:

☐ Provide Service Coordination for the Infant Toddler Program

☐ Provide Service Coordination for the Preschool Program

REFERRING PERSON / CONTACT NUMBER_____

Parent/ Caregiver: _____

Address: _____

City: _____

State: _____ Zip Code: _____County_____

Primary Number: _____; Best time to call: _____

Email Address :(required, if available) _____

If you would like one of our Parent to Parent-Regional Coordinators to contact you, please share your information and area of interest.

☐ I am interested in a Parent to Parent of PA match;

☐ I am interested in becoming a volunteer Peer Supporter.

☐ I would like to receive Parent to Parent of PA mailings.

By signing this Authorization to Release Information Form, you agree to allow your information to be released to the Parent to Parent of PA program for further contact.

Parent to Parent of Pennsylvania
6340 Flank Drive
Harrisburg, PA 17112
Email: p2pinfo@parenttoparent.org

Signature required:

Thank you for your interest in Parent to Parent of Pennsylvania