angel eyes

Child Loss Awareness

Authorization for Release of Information

PURPOSE OF DISCLOSURE

Release of individual/family contact information and basic facts regarding circumstances of individual/family involvement with Angel Eyes, including details of child death loss and assessment of needs to be met through the Peer Contact Program.

This information will be used to inform, plan, and provide for the Peer Contact Services for:

Your Name_____

I authorize Angel Eyes staff to release/exchange relevant information to designated Peer Contact including:

- ☐ My name, phone number, and email address;
- ☐ Basic information regarding the sudden, unexpected infant or toddler death I have experienced;
- ☐ My reasons, as stated on the Peer Contact Request Form, for seeking a Peer Contact; and
- ☐ Any information that Angel Eyes staff deems helpful in providing the best possible services and care through the peer partnership.

Signature_____

Printed Name_____

Date_____

If you have any questions throughout this process, please contact grief support coordinator, Rebecca, by phone or email.

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