Shasta Head Start
CHILD DEVELOPMENT, INC.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

(Health Care Providers, Dentists, Mental Health, WIC, County Health Department, Far Northern Regional Center)

Center Name:_____Center Fax:_____

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

I authorize the use or disclosure of the above-named child's health information as described below for the purpose of educational assessment and planning.

PLEASE **INITIAL** ALL TYPES OF INFORMATION TO BE USED OR DISCLOSED AND FILL IN THE SPECIFIC DATES OF SERVICE REQUESTED:

__ A list of Current Allergies
__ Recent and Current Medication List
__ Most Recent Well Child Exam
__ Most Recent Chart Notes
__ Height and Weight
__ Hearing/Vision Screening Results
__ Hemoglobin/Hematocrit and/or screening
__ Blood Lead Test and/or screening
__ Immunization Record
__TB Risk Assessment
__Most Recent Dental Exam
__Dental Treatment
__ Education Records
__ Progress Notes
__ Laboratory Results
__ X-ray or Imaging Reports
__ Psycho-Social Records/Information
__ Other_____

Disclosure of information to be made **from/to:**

_____
(Name of Facility in possession of information)

_____
(Mailing Address)

_____
(City and State)

Disclosure of information to be made **to/from:**

_____
(Name of Facility in possession of information)

_____
(Mailing Address)

_____
(City and State)

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization and I do not need to sign this form to assure participation.

Duration: This authorization shall become effective immediately and shall remain in effect until_____ (date) or *for one year from the date of signature if no date is entered*.

Cancellation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

Redisclosure: I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA)

A copy of this authorization is as valid as an original.

I understand that I have a right to receive a copy of this authorization for my records.

_____

Child's Name

_____ _____

Signature of Parent/Guardian Relationship to Child

Date: _____