

SHASTA HEAD START CHILD DEVELOPMENT, INC.

375 Lake Blvd., Suite 100

Redding, CA 96003

PHONE: (530) 241-1036 FAX: (530) 241-2703

Center: _____ Fax: (530) _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

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

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:**

- | | |
|---|--|
| <input type="checkbox"/> A list of Current Allergies | <input type="checkbox"/> Most Recent Dental Exam |
| <input type="checkbox"/> Most Recent Well Child Exam | <input type="checkbox"/> Height and Weight |
| <input type="checkbox"/> Recent and Current Medication List | <input type="checkbox"/> Hemoglobin/Hematocrit |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Blood Lead Test |
| <input type="checkbox"/> Education Records*** | |
| <input type="checkbox"/> Progress Notes from _____ to _____ (dates) | |
| <input type="checkbox"/> Laboratory Results from _____ to _____ (dates) | |
| <input type="checkbox"/> X-ray or Imaging Reports from _____ to _____ (dates) | |
| <input type="checkbox"/> Psycho-Social Records/Information*** | |
| <input type="checkbox"/> Other: IEP/Assessment reports*** | |

Disclosure of information to be made
from/to:
Shasta Head Start

Disclosure of information to be made
to/from: Shasta County Office of Ed.
S.E.L.P.A.

(Name of Facility in possession of
information)

375 Lake Blvd Suite 100

(Name of Facility in possession of
information)

1524 Magnolia Ave.

(Mailing Address)

Redding Ca. 96003

(Mailing Address)

Redding Ca. 96001-1513

(City and State)

(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: _____