SHASTA HEAD START CHILD DEVELOPMENT, INC.
375 Lake Blvd., Suite 100
Redding, CA 96003
PHONE: (530) 241-1036 FAX: (530) 241-2703
Center: _____Fax:_____

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:

__ A list of Current Allergies
__ Most Recent Well Child Exam
__ Recent and Current Medication List
__ Immunization Record
__ **Education Records*****
__ Progress Notes from _____to_____(dates)
__ Laboratory Results from _____to_____(dates)
__ X-ray or Imaging Reports from_____to_____(dates)
__ **Psycho-Social Records/Information*****
__ **Other IEP and Assessment Reports*****
__Most Recent Dental Exam
__ Height and Weight
__Hemoglobin/Hematocrit
__ Blood Lead Test

Disclosure of information to be made **to/from:**
Shasta Head Start
_____
(Name of Facility in possession of information)

375 Lake Blvd. Suite 100
_____
(Mailing Address)

Redding Ca. 96003
_____
(City and State)

Disclosure of information to be made **from/to:**
Siskiyou County Office of Education / S.E.L.P.A
_____
(Name of Facility in possession of information)

609 S Gold Street
_____
(Mailing Address)

Yreka Ca. 96097
_____

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: _____