West Central MN Communities Action, Inc.
Head Start 411 Industrial Park Blvd.
Elbow Lake MN 56531
Medical & Dental: 218-685-7090
Disability & Mental Health: 218-685-7084
Fax: 218-685-6747

AUTHORIZATION FOR RELEASE OF INFORMATION

Participant First & Last Name:_____DOB:_____Male Female

Parent/Legal Guardian name (please print): _____

Parent Initial	Reason for Release
	Most current physical exam record including a Hemoglobin and Lead result from any time since infancy, and current hearing & vision screening record.
	Most current dental exam record and any follow-up treatment records and/or appointment dates.
	Assessment Results/Evaluation Reports, Meeting Notices and IEP/IFSP/IIIP, if developed
	Mental Health Diagnostic Assessment
	Other (Specify):

I authorize WCMCA Head Start to release and exchange information in verbal or written form with:

Organization:_____

Address:_____City, State & ZIP:_____

Phone Number:_____ Fax: _____

For the following purpose:

- ☐ To meet Head Start requirements
- ☐ Determining eligibility for program services
- ☐ Planning and/or modifying program service plan

- I understand that once released the information will no longer be covered under Federal Privacy Laws.
- I understand that information not originated by WCMCA Head Start cannot be released to another facility.
- I understand I may refuse to release this information and the consequences of refusal have been explained to me.
- I understand that I may revoke this consent at any time (not retroactive) unless my participation in this program is a condition of probation, parole, or other court order. In that event, I understand that I may not revoke this consent until those conditions have been satisfied or after 60 days, whichever is later. I further understand that revocation must be in writing.
- I understand a photocopy or fax of this authorization will be treated in the same manner as the original.
- I understand this authorization is valid for existing records and those created after date of signature.
- I understand this authorization will automatically expire one year from the date of my signature.

_____ _____

Signature of Participant or Parent/Legal Guardian Date