

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

articipant First & Last Name:		DOB:	Male Female
arent/Legal	l 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 excha	nge information in <u>verbal or written</u> fo	rm with:
Organizatio	n:		
Address:		City, State & ZIP:	
Phone Number: Fax:			
□ То	owing purpose: meet Head Start requirements anning and/or modifying program service	Determining eligibility for plan	program services
> I underst	tand that once released the information v	vill no longer be covered under Federa	l Privacy Laws.
	tand that information not originated by W		•
	tand I may refuse to release this informa	•	·
condition until thos	tand that I may revoke this consent at ar n of probation, parole, or other court orde se conditions have been satisfied or after in writing.	er. In that event, I understand that I m	nay not revoke this consent
I underst	tand a photocopy or fax of this authorizat	tion will be treated in the same manne	r as the original.
I underst	tand this authorization is valid for existing	g records and those created after date	of signature.
> I underst	tand this authorization will automatically	expire one year from the date of my si	gnature.
Signature o	of Participant or Parent/Legal Guardian	Date	