Release of Information

Completing this release is voluntary and will not impact your eligibility for WIC or any other program/entity identified on this form.

I authorize the release of information for:

Participant(s)/Patient(s) Name(s): _____

_____

The information is to be released from (identify name/location):

☐ Healthcare Provider: _____

☐ WIC Program: _____

☐ Childcare Provider (including Head Start/Early Head Start):

_____

☐ Other: _____

The information may to be provided to (identify name/location):

☐ Healthcare Provider: _____

☐ WIC Program: _____

☐ Childcare Provider (including Head Start/Early Head Start):

_____

☐ Other: _____

The information that may be released from my records includes (i.e., the purpose):

☐ Any information from the record(s) that is requested by the receiving provider/program in the scope of their care and/or services of the participant(s) listed.

☐ Only information related to: _____

Release is valid until: □ 1 year from the date signed □ Other date (specify): _____

This information is to be released for a specific purpose only and may not be used by the recipient for any other reason. This information may not be shared with a third party.

I understand that I may revoke this authorization in writing at any time; except for information that may have already been shared. If this authorization has not been revoked, it will terminate one year from the date it was signed.

_____ _____

Participant/Parent/Guardian/Authorized Rep Signature Date