Head Start Authorization for Release of Information

Please fill out all sections of this form.

Patient Name: _____ Social Security #: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Phone Number#: _____

Send Information From: (Request Information From)

_____

_____

_____

Send to: (Head Start Program Address)

Martin County Head Start

Box 2189

Inez, KY 41224

ATTN: _____

I would like the records from the following dates: _____ through _____.

(This can be a specific date or more general: Example June 2018 or September 2017-May2018).

Please check the records you would like:

□ **Medical Exam/Physical** □ **Vision Exam** □ **Vision Screening**

□ **Dental Exam** □ **Blood Lead Screening** □ **Developmental Screening**

□ **Dental Treatment** □ **Hearing Screening** □ **Hemoglobin/Hematocrit**

□ **Blood Pressure** □ **Other** _____

Sharing of Special Protected Records: I authorize the sharing of information about:

a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) ____ YES ____ NO
b. The diagnosis or treatment of drug and /or alcohol abuse, ____ YES ____ NO
c. The treatment and/or consultation for mental health or psychiatric disorders ____ YES ____ NO

Reason records are needed (check all that apply)

____ For Head Start Health Requirements ____ Personal Use ____ Other: _____

I understand that I do not have to sign this authorization and that the Big Sandy Area Community Action Program, Inc., may not condition treatment or payment on whether I sign this authorization. However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that the Big Sandy Area Community Action Program, Inc., has already taken action in reliance on my authorization. I further understand that I may inspect or copy the PHI to be used or disclosed.

Written statement that I want to revoke my authorization should be delivered to:

Martin CO Head Start Box 2189 Inez KY 41224 ATTN:

This authorization expires on (please list a specific date): _____
Or ninety (90) days from date signed (whichever occurs first) and will automatically become null and void without my express revocation.

_____ _____

Date **Signature of Parent/guardian**

_____

Relationship to Patient