



# 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