



Spokane County Head Start/ECEAP/EHS AUTHORIZATION TO DISCLOSE AND RECEIVE INFORMATION

PARENT/CHILD INFORMATION

Child's name _____ Date of birth ____/____/____

Parent/legal guardian (please print) _____

INFORMATION TO BE RELEASED FROM:

Name of facility or provider _____

Mailing address _____

Phone number _____ Fax number _____

ATTN _____

INFORMATION TO BE SENT TO:

Head Start/ECEAP/EHS site _____

Mailing address _____

Phone number _____ Fax number _____

ATTN _____

INFORMATION TO BE RELEASED: (check as appropriate)

- Hearing screening results
- Vision screening results
- IEP/IFSP
- Hematocrit results
- Developmental assessments
- Blood lead level results
- Other specific information _____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE

To meet Head Start/ECEAP/EHS performance standard requirements

PARENT AUTHORIZATION

I understand that I may revoke this authorization, in writing, at any time. Information received via this request will not be re-disclosed to any other entity without an additional parent signed release. The information will be disposed of in accordance with state and federal laws and Head Start/ECEAP/EHS policies and procedures.

I give my specific authorization for these records to be released, excluding any State and/or Federally protected information.

Signature _____ Date ____/____/____
(Authorized parent, legal guardian, or authorized representative)

This authorization will expire 90 days from the date signed.